

**IN THE UNITED STATES DISTRICT COURT  
FOR THE MIDDLE DISTRICT OF TENNESSEE  
AT NASHVILLE**

JOHN B. CARRIE G., JOSHUA M., MEAGAN A.	)
and ERICA A., by their next friend, L.A.;	)
DUSTN P. by his next friend, LINDA C.	)
BAYLIS. By her next friend, C.W.;	)
JAMES D. by his next friend, Susan H.;	)
ELSIE H. by her next friend, Stacy Miller;	)
JULIAN C. by his next friend, Shawn C.;	)
TROY D. by his next friend, T.W.;	)
RAY M. by his next friend, P.D.;	)
ROSCOE W. by his next friend, K.B.;	)
JACOB R. by his next friend, Kim R.;	)
JUSTIN S. by his next friend, Diane P.;	)
ESTEL W. by his next friend, E.D.;	)
individually and on behalf of all others	)
similarly situated,	)
	)
Plaintiffs,	)
	)
	)NO. 3-98-0168
v.	)Judge Nixon
	)
	)
NANCY MENKE, Commissioner,	)
Tennessee Department of Health;	)
THERESA CLARKE, Assistant Commissioner	)
Bureau of TennCare; and	)
GEORGE HATTAWAY, Commissioner	)
Tennessee Department of Children's Services	)
	)
Defendants.	)
	)

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**JULY 1999 SEMI-ANNUAL PROGRESS REPORT**

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**JULY 1999 SEMI-ANNUAL PROGRESS REPORT**

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Pursuant to Paragraph 104 of the Consent Decree entered on March 11, 1998, the state Defendants agreed to file a semi-annual report with this Court and plaintiffs' counsel regarding

their compliance with the terms of this order. Such reports are to be filed on July 31<sup>st</sup> and January 31<sup>st</sup> of each year. Said reports "shall contain information, validated by the applicable audit and testing procedures outlined herein, which accurately and fully reflect the status of the State's compliance with each of the applicable requirements of this order..."

Attached to this notice is a copy of the Semi-Annual Progress Report for the period ending July 31, 1999. This Report contains the following components:

1. Overview of activities during report period
2. Attachment A: "Phase I" of the State Child Health Insurance Program ("SCHIP") plan for Tennessee
3. Attachment B: MCO/BHO EPSDT Activities Report
4. Attachment C: Recommendations for Mental Health Crisis Services
5. Attachment D: Progress Report  
This document, in chart form, provides the paragraph number, topic, deadline and summary of progress regarding the particular
6. Attachment E: Behavioral and Developmental Screening Guidelines
7. Attachment F: Revised Proposed Remedial Plan
8. Attachment G: DCS Complaint Form
9. Attachment H: MCO and BHO DCS Liaisons
10. Attachment I: MCO and BHO EPSDT Coordinators
11. Attachment J: Case Management Monitoring Plan
12. Attachment K: TennCare Standard Operating Procedure 036 and Addendum 1
13. Attachment L: Review of Appeals

Pursuant to paragraph 104 of the Consent Decree, this semi-annual report is being provided to plaintiffs' local counsel.

- 335 case managers and supervisors,
- 46 persons to staff a centralized intake service to receive reports of child abuse and neglect,
- 10 persons to work as a Child Protective Services Special Assist Team, which will be assigned to large scale investigations of alleged child abuse, and
- 6 administrative personnel.

Overseeing the implementation of the Settlement Agreement is Director of Compliance Kent Berkley, formerly assistant general counsel for DCS, and an independent and neutral monitor, Sheila Agneil, who is from Kansas City and who has performed a similar role in two other states, New Mexico and Missouri. A technical assistance committee has been created to assist in monitoring quality assurance and placement of children in a timely manner.

### **3. EPSDT Steering Committee**

The EPSDT Steering Committee, which was appointed in October 2000 by TennCare Director Mark Reynolds and which continues to be chaired by Commissioner Reynolds, has met on an every-other-week basis for the purpose of analyzing EPSDT issues and discussing new projects. The committee is directly responsible for initiating many of the activities outlined in these pages.

### **4. TennCare Select**

The proposed Revised Remedial Plan submitted to the Court in December 2000 called for a “carve-out” managed care model for children. This “carve-out,” which is called TennCare Select, was developed during this reporting period and implemented on July 1, 2001. TennCare Select was designed to accomplish several purposes, chief among them being creation of a vehicle for providing more smoothly coordinated services to children in DCS state custody and certain other special needs children. The framework for choosing which children would be considered “special needs” children was taken from a “Dear Medicaid Director” letter issued by the Health Care Financing Administration (now Centers for Medicare & Medicaid Services) in January. (See Attachment B.)

TennCare Select incorporates the Centers of Excellence and Best Practice Networks envisioned by the Remedial Plan and the Revised Remedial Plan. (See page 12 for more information on the Centers of Excellence and the Best Practice Guidelines.)

### **5. Implementation Team (Remedial Plan)**

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Overview

Major Accomplishments During January through July 1999

Attachments

- A. "Phase I" of the State Child Health Insurance Program ("SCHIP") Plan for Tennessee
- B. MCO/BHO EPSDT Activities Report
- C. Recommendations for Mental Health Crisis
- D. Progress Report
- E. Behavioral and Developmental Screening Guidelines
- F. Revised Proposed Remedial Plan
- G. DCS Complaint Fax
- H. MCO and BHO DCS Liaison
- I. MCO and BHO EPSDT Coordinators
- J. Case Management Monitoring Plan
- K. TennCare Standard Operating Procedure 036 and Addendum 1
- L. Review of Appeals

**Section 1. General Description and Purpose of the State Child Health Plans** (Section 2101)

The state will use funds provided under Title XXI primarily for (Check appropriate box):

- 1.1. ☐ Obtaining coverage that meets the requirements for a State Child Health Insurance Plan (Section 2103); **OR**
- 1.2. ☒ Providing expanded benefits under the State's Medicaid plan (Title XIX); **OR**
- 1.3. ☐ A combination of both of the above.

# **Semi-Annual Progress Report**

**EPSDT Consent  
Decree**

**July 30, 1999**

**Section 2. General Background and Description of State Approach to Child Health Coverage (Section 2102 (a)(1)-(3) and Section 2105 (c)(7)(A)-(B))**

- 2.1. Describe the extent to which, and manner in which, children in the state including targeted low-income children and other classes of children, by income level and other relevant factors, such as race and ethnicity and geographic location, currently have creditable health insurance (as defined in Section 2110 (c)(2)). To the extent feasible, make a distinction between creditable coverage under public health insurance programs and public-private partnerships. (See Section 10 for annual report requirements.)**

During the past five years, the Center for Business and Economic Research at the University of Tennessee has conducted an annual survey of Tennesseans to determine their insurance status, perceptions about quality of medical care, satisfaction with insurance (including TennCare), and use of medical facilities. According to the report published in March 1998, 5.9 percent of Tennesseans, or 318,708 individuals, were uninsured in 1997. Almost 4 of 5 of those interviewed indicated that their primary reason for remaining uninsured was inability to pay for coverage, while another 15 percent said they just did not get around to it. About 1 in 10 said they did not need health insurance. Nearly a third of those who identified themselves as uninsured had family incomes below \$20,000 per year.

There are currently about 500,000 children under age 18 on TennCare. In 1996, the Center for Business and Economic Research at the University of Tennessee estimated that there were 68,000 uninsured children in Tennessee. Considering that the total number of Tennessee children under age 18 in 1996 was 1.322 million (as estimated by the U. S. Bureau of the Census), we can conclude that about 1.254 million had insurance coverage, including TennCare. It appears that about 750,000 Tennessee children under age 18 had some kind of private or employer-sponsored health insurance other than TennCare in 1996.

As discussed under Section 2.2.2 below, there are currently no comprehensive health insurance programs that involve formal public-private partnerships in Tennessee.

Of the 500,000 children with TennCare, about 400,000 are Medicaid-eligible and the remaining 100,000 are enrolled as Uninsureds or Uninsurables. The overwhelming majority of children participating in TennCare are from low-income families.

- 2.2 Describe the current state efforts to provide or obtain creditable health coverage for uncovered children by addressing: (Section 2102 (a)(2))**

- 2.2.1 The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in public health insurance programs (i.e., Medicaid and state-only child health insurance):**

Tennessee has moved aggressively to identify and enroll uninsured children who are eligible to participate in TennCare. For the first year of the TennCare Program (1994), there was an Uninsured eligibility category, which was open to individuals (both children and adults) who did not have access to health insurance through an employer or family member as of a specified date in the past, which initially was March 1, 1993. There was massive publicity about the new program. The State retained a marketing firm to assist in the preparation of videos, television and radio spots, and other materials to encourage people to enroll. Advocates participated in radio and television interviews all over the State. A large TennCare Information Line was established to help people with questions, and local health departments conducted major enrollment efforts in their communities. Providers such as community hospitals also worked to assist people in enrolling in TennCare.

The success of these efforts is shown by the fact that the Uninsured category had to be closed at the end of December 1994 because the State was nearing its cap on the number of people who could be enrolled in TennCare. (The Uninsured category remained open after 1994 for two distinct groups: people losing Medicaid eligibility and people losing access to COBRA coverage. Individuals in both groups had to lack access to health insurance through an employer or a family member, and they had to apply within specified timeframes after losing coverage.) Even though the Uninsured category was closed, however, the enrollment of Medicaid eligibles and Uninsurables (meaning individuals who had been turned down for health insurance because of a medical condition) continued without interruption.

On April 1, 1997, Governor Don Sundquist re-opened the TennCare Uninsured category for children under age 18 who lacked access to health insurance through an employer or a family member. Local health departments were the key players in conducting outreach for this new program. A video was produced (including a version for individuals with hearing impairments) for use in informing families about the new program. Health department staff distributed flyers, posters, signs, and report card inserts to WIC and Head Start programs, offices of the Department of Human Services, Legal Aid offices, churches, schools, day care and family resource centers, after-school programs, health fairs, hospital emergency rooms, children's museums, county hospital carnivals, the circus, fast food/grocery/variety stores used by low-income families, child advocacy groups, minority health coalitions, volunteers, physicians' offices, factories, companies not offering health coverage, and bank drive-in windows. Parenting fairs have been held at schools. Contests have been held among clerks at local health departments to see who could enroll the most children. Presentations have been made at universities and neighborhood associations, and the print and broadcast media have been used as well. Local health departments personally contacted families who had

applied for coverage for uninsured children after the Uninsured category was closed in December 1994 and told them about this new opportunity to enroll their children.

In January 1998, Governor Sundquist expanded the Uninsured category to include children under age 19 without access to health insurance. In addition, he established an open enrollment period for children under age 19 whose families had access to health insurance but could not afford it. Uninsured children who had access to health insurance are allowed to enroll in TennCare only if their family incomes do not exceed 200% of poverty.

PHASE I of Tennessee's SCHIP Plan: Extension of Medicaid coverage to children up to the age of 19 whose family incomes do not exceed 100% poverty. To date, 9,732 children have been enrolled who meet the criteria for this category.

**2.2.2 The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in health insurance programs that involve a public-private partnership:**

There has always been collaboration between public health and welfare agencies and private insurance companies around certain individuals with special needs. While limited assistance to these people (persons with AIDS/HIV, persons with sexually transmitted diseases, handicapped children, persons with alcohol and drug problems, children in State custody, etc.) is provided through various State agencies, there are currently no comprehensive health insurance programs that involve formal public-private partnerships in Tennessee.

**2.3 Describe how the new State Title XXI program(s) is(are) designed to be coordinated with such efforts to increase the number of children with creditable health insurance so that only eligible targeted low-income children are covered: (Section 2102 (a)(3))**

The outreach efforts described in Section 2.2.1 have been specifically designed to apply to the new State Title XXI program.

**Section 3. General Contents of State Child Health Plan (Section 2102)(a)(4))**

**[X] Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 4.**

3.1. Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children: (Section 2102)(a)(4)

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3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children: (Section 2102)(a)(4)

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**Section 4. Eligibility Standards and Methodology. (Section 2102(b))**

**[X] Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 5.**

4.1. The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. (Section 2102)(b)(1)(A))

- 4.1.1. ☐ Geographic area served by the Plan: \_\_\_\_\_
- 4.1.2. ☐ Age: \_\_\_\_\_
- 4.1.3. ☐ Income: \_\_\_\_\_
- 4.1.4. ☐ Resources (including any standards relating to spend downs and disposition of resources): \_\_\_\_\_
- 4.1.5. ☐ Residency: \_\_\_\_\_
- 4.1.6. ☐ Disability Status (so long as any standard relating to disability status does not restrict eligibility): \_\_\_\_\_
- 4.1.7. ☐ Access to or coverage under other health coverage: \_\_\_\_\_
- 4.1.8. ☐ Duration of eligibility \_\_\_\_\_
- 4.1.9. ☐ Other standards (identify and describe): \_\_\_\_\_  
\_\_\_\_\_

4.2. The state assures that it has made the following findings with respect to the eligibility standards in its plan: (Section 2102)(b)(1)(B))

- 4.2.1. ☐ These standards do not discriminate on the basis of diagnosis.
- 4.2.2. ☐ Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.
- 4.2.3. ☐ These standards do not deny eligibility based on a child having a pre-existing medical condition.

- 4.3. Describe the methods of establishing eligibility and continuing enrollment.  
(Section 2102)(b)(2))
- 

- 4.4. Describe the procedures that assure:

- 4.4.1. Through intake and followup screening, that only targeted low-income children who are ineligible for either Medicaid or other creditable coverage are furnished child health assistance under the state child health plan. (Section 2102)(b)(3)(A))
- 

- 4.4.2. That children found through the screening to be eligible for medical assistance under the state Medicaid plan under Title XIX are enrolled for such assistance under such plan. (Section 2102)(b)(3)(B))
- 

- 4.4.3. That the insurance provided under the state child health plan does not substitute for coverage under group health plans. (Section 2102)(b)(3)(C))
- 

- 4.4.4. The provision of child health assistance to targeted low-income children in the state who are Indians (as defined in section 4(c) of the Indian Health Care Improvement Act, 25 U.S.C. 1603(c). (Section 2102)(b)(3)(D))
- 

- 4.4.5. Coordination with other public and private programs providing creditable coverage for low-income children. (Section 2102)(b)(3)(E))
-

**Section 5. Outreach and Coordination (Section 2102 (c))**

**Describe the procedures used by the state to accomplish:**

**5.1 Outreach to families of children likely to be eligible for assistance or under other public or private health coverage to inform them of the availability of, and to assist them in enrolling their children in such a program: (Section 2102 (c)(1))**

There are local health departments in all 95 counties of Tennessee. These agencies are the focal point for outreach efforts for the new Title XXI program and have worked very aggressively to find uninsured children and to let their families know about the new program. Families actually enroll their children at the health department, where there are staff persons trained and available to assist them. Examples of specific outreach activities are presented in Section 2.2.1 of this application.

**5.2 Coordination of the administration of this program with other public and private health insurance programs: (Section 2102 (c)(2))**

The new Title XXI program is an expansion of the existing TennCare Program. Since Tennessee has not opted to use Title XXI funds to assist individuals in purchasing private insurance, there is not a necessity for coordination with private health insurance programs. TennCare does, of course, coordinate with private insurance programs for those Medicaid-eligible children also having private insurance, but the Title XXI children are by definition not included in this group.

**Section 6. Coverage Requirements for Children's Health Insurance (Section 2103)**

[X]

**Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 7.**

- 6.1. The state elects to provide the following forms of coverage to children:  
(Check all that apply.)

6.1.1. ☐ Benchmark coverage; (Section 2103(a)(1))

6.1.1.1. ☐ FEHBP-equivalent coverage; (Section 2103(b)(1))  
(If checked, attach copy of the plan.)

6.1.1.2. ☐ State employee coverage; (Section 2103(b)(2)) (If checked, identify the plan and attach a copy of the benefits description.)

6.1.1.3. ☐ HMO with largest insured commercial enrollment (Section 2103(b)(3)) (If checked, identify the plan and attach a copy of the benefits description.)

6.1.2. ☐ Benchmark-equivalent coverage; (Section 2103(a)(2)) Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Please attach signed actuarial report that meets the requirements specified in Section 2103(c)(4). **See instructions.**

6.1.3. ☐ Existing Comprehensive State-Based Coverage; (Section 2103(a)(3)) [Only applicable to New York; Florida; Pennsylvania] Please attach a description of the benefits package, administration, date of enactment. If "existing comprehensive state-based coverage" is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for "existing comprehensive state-based coverage."

6.1.4. ☐ Secretary-Approved Coverage. (Section 2103(a)(4))

6.2. The state elects to provide the following forms of coverage to children:  
(Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) (Section 2110(a))

- 6.2.1. ☐ Inpatient services (Section 2110(a)(1))
- 6.2.2. ☐ Outpatient services (Section 2110(a)(2))
- 6.2.3. ☐ Physician services (Section 2110(a)(3))
- 6.2.4. ☐ Surgical services (Section 2110(a)(4))
- 6.2.5. ☐ Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))
- 6.2.6. ☐ Prescription drugs (Section 2110(a)(6))
- 6.2.7. ☐ Over-the-counter medications (Section 2110(a)(7))
- 6.2.8. ☐ Laboratory and radiological services (Section 2110(a)(8))
- 6.2.9. ☐ Prenatal care and prepregnancy family services and supplies (Section 2110(a)(9))
- 6.2.10. ☐ Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Section 2110(a)(10))
- 6.2.11. ☐ Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services (Section 2110(a)(11))
- 6.2.12. ☐ Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) (Section 2110(a)(12))
- 6.2.13. ☐ Disposable medical supplies (Section 2110(a)(13))
- 6.2.14. ☐ Home and community-based health care services (See instructions) (Section 2110(a)(14))
- 6.2.15. ☐ Nursing care services (See instructions) (Section 2110(a)(15))
- 6.2.16. ☐ Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest (Section 2110(a)(16))
- 6.2.17. ☐ Dental services (Section 2110(a)(17))
- 6.2.18. ☐ Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))
- 6.2.19. ☐ Outpatient substance abuse treatment services (Section 2110(a)(19))
- 6.2.20. ☐ Case management services (Section 2110(a)(20))

- 6.2.21. ☐ Care coordination services (Section 2110(a)(21))
- 6.2.22. ☐ Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))
- 6.2.23. ☐ Hospice care (Section 2110(a)(23))
- 6.2.24. ☐ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) (Section 2110(a)(24))
- 6.2.25. ☐ Premiums for private health care insurance coverage (Section 2110(a)(25))
- 6.2.26. ☐ Medical transportation (Section 2110(a)(26))
- 6.2.27. ☐ Enabling services (such as transportation, translation, and outreach services) (See instructions) (Section 2110(a)(27))
- 6.2.28. ☐ Any other health care services or items specified by the Secretary and not included under this section (Section 2110(a)(28))

- 6.3. **Waivers - Additional Purchase Options.** If the state wishes to provide services under the plan through cost effective alternatives or the purchase of family coverage, it must request the appropriate waiver. Review and approval of the waiver application(s) will be distinct from the state plan approval process. To be approved, the state must address the following: (Section 2105(c)(2) and(3))

- 6.3.1. ☐ **Cost Effective Alternatives.** Payment may be made to a state in excess of the 10% limitation on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the state to administer the plan, if it demonstrates the following:

- 6.3.1.1. Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above; **Describe the coverage provided by the alternative delivery system. The state may cross reference section 6.2.1 - 6.2.28.** (Section 2105(c)(2)(B)(i))

- 6.3.1.2. The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above; and **Describe the cost of such coverage on an average per child basis.** (Section 2105(c)(2)(B)(ii))

- 6.3.1.3. The coverage must be provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section 1886(d)(5)(F) or 1923 of the Social Security Act. **Describe the community based delivery system.** (Section 2105(c)(2)(B)(iii))

6.3.2. ☐ **Purchase of Family Coverage.** Describe the plan to provide family coverage. Payment may be made to a state for the purpose of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children, if it demonstrates the following: (Section 2105(c)(3))

6.3.2.1. Purchase of family coverage is cost-effective relative to the amounts that the state would have paid to obtain comparable coverage only of the targeted low-income children involved; and **(Describe the associated costs for purchasing the family coverage relative to the coverage for the low income children.)** (Section 2105(c)(3)(A))

6.3.2.2. The state assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. (Section 2105(c)(3)(B))

**Section 7. Quality and Appropriateness of Care**

**[X] Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 8.**

- 7.1. Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. (2102(a)(7)(A))
- 

Will the state utilize any of the following tools to assure quality?  
(Check all that apply and describe the activities for any categories utilized.)

- 7.1.1. ☐ Quality standards  
7.1.2. ☐ Performance measurement  
7.1.3. ☐ Information strategies  
7.1.4. ☐ Quality improvement strategies

- 7.2. Describe the methods used, including monitoring, to assure access to covered services, including emergency services. (2102(a)(7)(B))
-

**Section 8. Cost Sharing and Payment** (Section 2103(e))

[X] **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan**, and continue on to Section 9.

8.1. Is cost-sharing imposed on any of the children covered under the plan?

8.1.1. ☐ YES

8.1.2. ☐ NO, skip to question 8.5.

8.2. Describe the amount of cost-sharing and any sliding scale based on income:  
(Section 2103(e)(1)(A))

8.2.1. Premiums: \_\_\_\_\_

8.2.2. Deductibles: \_\_\_\_\_

8.2.3. Coinsurance: \_\_\_\_\_

8.2.4. Other: \_\_\_\_\_

8.3. Describe how the public will be notified of this cost-sharing and any differences based on income: \_\_\_\_\_

8.4. The state assures that it has made the following findings with respect to the cost sharing and payment aspects of its plan: (Section 2103(e))

8.4.1. ☐ Cost-sharing does not favor children from higher income families over lower income families. (Section 2103(e)(1)(B))

8.4.2. ☐ No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2))

8.4.3. ☐ No child in a family with income less than 150% of the Federal Poverty Level will incur cost-sharing that is not permitted under 1916(b)(1).

8.4.4. ☐ No Federal funds will be used toward state matching requirements.  
(Section 2105(c)(4))

8.4.5. ☐ No premiums or cost-sharing will be used toward state matching requirements. (Section 2105(c)(5))

8.4.6. ☐ No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title.  
(Section 2105(c)(6)(A))

8.4.7. ☐ Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. (Section 2105(d)(1))

- 8.4.8. ☐ No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. (Section 2105)(c)(7)(B))
- 8.4.9. ☐ No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). (Section 2105)(c)(7)(A))
- 8.5. Describe how the state will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family's annual income for the year involved: (Section 2103(e)(3)(B))
- 
- 8.6. The state assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan:
- 8.6.1. ☐ The state shall not permit the imposition of any pre-existing medical condition exclusion for covered services (Section 2102(b)(1)(B)(ii)); **OR**
- 8.6.2. ☐ The state contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.3.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA (Section 2109(a)(1),(2)). Please describe:
-

## **Section 9. Strategic Objectives and Performance Goals for the Plan Administration (Section 2107)**

### **9.1 Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children: (Section 2107 (a)(2))**

- Conduct outreach through local health departments to schools, churches, agencies and businesses likely to serve or come in contact with low-income families with children.
- Make the TennCare application process as simple as possible.
- Target special outreach efforts to the families of uninsured homeless children.
- Explore non-traditional outreach approaches such as use of TennCare enrollees in pilot communities to develop, implement, and evaluate strategies for enrolling uninsured children.

### **9.2 Specify one or more performance goals for each strategic objective identified: (Section 2107 (a)(3))**

- Each local health department will conduct outreach activities appropriate to the community in which that health department is located.
- The current simplified TennCare application form and enrollment strategies will be evaluated regularly to determine if improvements are needed and appropriate.
- The Tennessee Health Care Campaign, which is a statewide coalition of grassroots consumer organizations, is being assisted in implementing a community-based pilot intervention program targeting the enrollment in TennCare of low-income uninsured children. This program, which has been funded by the Robert Wood Johnson Foundation, emphasizes the development and implementation of social marketing techniques for encouraging enrollment.

### **9.3 Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the state's performance, taking into account suggested performance indicators as specified below or other indicators the state develops: (Section 2107 (a)(4)(A),(B))**

- Tennessee will continue to conduct annual analyses of the percentage of uninsured citizens, including children.
- Tennessee will move toward full implementation of EPSDT for all TennCare-enrolled children under the age of 21. Specific goals include the following:
  - By September 1999, the State will achieve a 100% EPSDT screening rate for all TennCare-enrolled children in the physical custody of the Department of Children's Services.

- By September 2001, the State will achieve an 80% EPSDT screening rate for all other TennCare-enrolled children.
- By September 2003, the State will achieve an 80% dental screening rate for all other TennCare-enrolled children.
- TennCare will conduct an annual statistically valid medical record review to determine whether all of the required screening components are being documented in children's medical records.

**Check the applicable suggested performance measurements listed below that the state plans to use: (Section 2107 (a)(4))**

- 9.3.1 ☐ **The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.**
- 9.3.2 ☐ **The reduction in the percentage of uninsured children.**
- 9.3.3 ☐ **The increase in the percentage of children with a usual source of care.**
- 9.3.4 ☐ **The extent to which outcome measures show progress on one or more of the health problems identified by the state.**
- 9.3.5 ☐ **HEDIS Measurement Set relevant to children and adolescents younger than 19.**
- 9.3.6 ☐ **Other child appropriate measurement set. List or describe the set used.**

Tennessee is presently using a modified version of the HEDIS Measurement Set. Measurement is occurring in the following areas:

- Infant mortality rate
- Infant case rate fatality rate (defined as the number of deaths of children under the age of one born within a given year divided by the total number of children born within that year)
- Percentage of prenatal care start
- Percentage of low birthweight deliveries
- Percentage of preterm deliveries
- Well child visits for children ages 3, 4, 5, and 6
- Dental visits for children under the age of 21
- Inpatient admissions for all ambulatory care sensitive diagnoses (meaning diagnoses of conditions which are sensitive to management in the ambulatory care setting, given timely and appropriate primary care)
- Inpatient admissions for pediatric asthma (a specific childhood illness which is sensitive to treatment with timely and appropriate primary care)
- Childhood immunizations

It is expected that new measurements, including measurements of the effectiveness of mental health services, will be added to this list as the reporting of encounter data becomes even more consistent and reliable.

**9.3.7 ☐ If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:**

**9.3.7.1 ☐ Immunizations**

**9.3.7.2 ☐ Well child care**

**9.3.7.3 ☐ Adolescent well visits**

**9.3.7.4 ☐ Satisfaction with care**

**9.3.7.5 ☐ Mental health**

**9.3.7.6 ☐ Dental care**

**9.3.7.7 ☐ Other, please list: \_\_\_\_\_**

**9.3.8 ☐ Performance measures for special targeted populations.**

**9.4. [X] The state assures it will collect all data, maintain records, and furnish furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. (Section 2107 (b)(1))**

**9.5 [X] The state assures it will comply with the annual assessment and evaluation required under Section 10.1 and 10.2. (See Section 10) Briefly describe the state's plans for these annual assessments and reports. (Section 2107 (b)(2))**

Tennessee will work with HCFA to assure performance of the required annual assessment and evaluation. Tennessee collects a wealth of encounter data from its MCOs and BHOs, as well as demographic data on enrollees that will allow us to group data according to the age, income criteria, and geographic location specified. Provision of information on race and ethnicity is an optional requirement under TennCare, but we will provide what information we have. The number of children without creditable coverage will be estimated on the basis of ongoing annual surveys performed by the University of Tennessee Center for Business and Economic Research and will not be broken down by age, income criteria, geographic location, or race and ethnicity.

**9.6 [X] The state assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review or audit. (Section 2107 (b)(3))**

- 9.7 [X] The state assures that, in developing performance standards, it will modify those measures to meet national requirements when such requirements are developed.
- 9.8 [X] The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: (Section 2107 (e))
- 9.8.1 ☐ Section 1902 (a)(4)(C) (relating to conflict of interest standards)
  - 9.8.2 ☐ Paragraphs (2), (16), and (17) of Section 1903(i) (relating to limitations on payment)
  - 9.8.3 ☐ Section 1902 (w) (relating to limitations on provider donations and taxes)
  - 9.8.4 ☐ Section 1115 (relating to waiver authority)
  - 9.8.5 ☐ Section 1116 (relating to administrative and judicial review), but only insofar as consistent with Title XXI
  - 9.8.6 ☐ Section 1124 (relating to disclosure of ownership and related information)
  - 9.8.7 ☐ Section 1126 (relating to disclosure of information about certain convicted individuals)
  - 9.8.8 ☐ Section 1128A (relating to civil monetary penalties)
  - 9.8.9 ☐ Section 1128B (d) (relating to criminal penalties for certain additional charges)
  - 9.8.10 ☐ Section 1132 (relating to periods within which claims must be filed)
- 9.9 Describe the process used by the state to accomplish involvement of the public in the design and implementation of the plan and the method for insuring ongoing public involvement. (Section 2107 (c))

The new SCHIP plan has received a great deal of publicity in our State. Advocates were invited to meet with the Commissioner of the Department of Health and provide comments prior to the initial submission of the plan in December 1997. The Governor has held press conferences describing the plan, and a summary of the plan has been posted on the TennCare website. Detailed information about the plan has been sent to all requesting it. A public hearing was held on proposed rules for the program. Ongoing public involvement, including discussions with advocates and provider groups such as the Tennessee Chapter of the American Academy of Pediatrics is occurring regularly.

- 9.10 Provide a budget for this program. Include details on the planned use of funds and sources of the non-Federal share of plan expenditures. (Section 2107 (d))

See attached

**Section 10. Annual Reports and Evaluations (Section 2108)**

10.1. Annual Reports. The state assures that it will assess the operation of the state plan under this Title in each fiscal year, including: (Section 2108(a)(1),(2))

10.1.1. [X] The progress made in reducing the number of uncovered low-income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and

10.1.2. [X] Report to the Secretary, January 1 following the end of the fiscal year, on the result of the assessment.

Below is a chart listing the types of information that the state's annual report might include. Submission of such information will allow comparisons to be made between states and on a nationwide basis.

<u>Attributes of Population</u>	<u>Number of Children with Creditable Coverage</u> <u>XIX    OTHER CHIP</u>	<u>Number of Children without Creditable Coverage</u>	<b>TOTAL</b>
Income Level:			
< 100%			
≤ 133%			
≤ 185%			
≤ 200%			
> 200%			
<u>Age</u>			
0 - 1			
1 - 5			
6 - 12			
13 - 18			
<u>Race and Ethnicity</u>			
American Indian or Alaskan Native			
Asian or Pacific Islander			
Black, not of Hispanic origin			
Hispanic			
White, not of Hispanic origin			
<u>Location</u>			
MSA			
Non-MSA			

10.2. [X] State Evaluations. The state assures that by March 31, 2000 it will submit to the Secretary an evaluation of each of the items described and listed below:  
**(Section 2108(b)(A)-(H))**

10.2.1. [X] An assessment of the effectiveness of the state plan in increasing the number of children with creditable health coverage.

10.2.2. A description and analysis of the effectiveness of elements of the state plan, including:

10.2.2.1. [X] The characteristics of the children and families assisted under the state plan including age of the children, family income, and the assisted child's access to or coverage by other health insurance prior to the state plan and after eligibility for the state plan ends;

10.2.2.2. [X] The quality of health coverage provided including the types of benefits provided;

10.2.2.3. [X] The amount and level (including payment of part or all of any premium) of assistance provided by the state;

10.2.2.4. [X] The service area of the state plan;

10.2.2.5. [X] The time limits for coverage of a child under the state plan;

10.2.2.6. [X] The state's choice of health benefits coverage and other methods used for providing child health assistance, and

10.2.2.7. [X] The sources of non-Federal funding used in the state plan.

10.2.3. [X] An assessment of the effectiveness of other public and private programs in the state in increasing the availability of affordable quality individual and family health insurance for children.

- 10.2.4. [X] A review and assessment of state activities to coordinate the plan under this Title with other public and private programs providing health care and health care financing, including Medicaid and maternal and child health services.
- 10.2.5. [X] An analysis of changes and trends in the state that affect the provision of accessible, affordable, quality health insurance and health care to children.
- 10.2.6. [X] A description of any plans the state has for improving the availability of health insurance and health care for children.
- 10.2.7. [X] Recommendations for improving the program under this Title.
- 10.2.8. [X] Any other matters the state and the Secretary consider appropriate.
- 10.3. [X] The state assures it will comply with future reporting requirements as they are developed.
- 10.4. [X] The state assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.

LIGIBLES

ASIC CAPITATION COST PRIOR TO BHO WAIVER	\$3,737,962.768	\$1,836,788.700	\$1,967,569.300	\$2,107,659.700	\$5,912,017.700
ASIC CAPITATION COST AFTER TO BHO WAIVER	\$3,289,375.612	\$56,123.500	\$58,929.700	\$61,876.200	\$176,929.400
ASIC CAPITATION COST CHIPS	\$38,557.257	\$294,285.300	\$315,235.300	\$337,680.000	\$947,200.600
APITATION COST-BHO WAIVER	\$578,473.640	\$10,851.700	\$11,394.300	\$11,964.000	\$34,210.000
APITATION COST-BHO CHIPS	\$7,455.178	\$2,198,049.200	\$2,353,128.600	\$2,519,179.900	\$7,070,357.700
TOTAL CAPITATION COST PER YEAR	\$7,651,824.453	\$2,198,049.200	\$2,353,128.600	\$2,519,179.900	\$7,070,357.700
UPPLEMENTAL CAPITATION ADJUSTMENTS					
SPMI THROUGH 6-30-96	\$262,815.938	\$0	\$0	\$0	\$0
A. CHILDRENS PLAN	\$508,930.457	\$99,121.400	\$104,077.500	\$109,281.400	\$312,480.300
B. CHILDRENS PLAN-CHIPS	\$4,073.550	\$5,635.100	\$5,916.900	\$6,212.700	\$17,764.700
HIGH COST CHRONIC CONDITIONS	\$195,000.000	\$40,000.000	\$40,000.000	\$40,000.000	\$120,000.000
BHO(MENTAL HEALTH CLINIC POOL PAYMENTS)	\$16,050.000	\$0	\$0	\$0	\$0
TOTAL CAPITATION CASH COST	\$8,638,694.398	\$2,342,805.700	\$2,503,123.000	\$2,674,674.000	\$7,520,602.700

RESERVE FUND POOL					
PRIMARY CARE ASSISTANCE FUND	\$26,881.104	\$0	\$0	\$0	\$0
MAIPRACTICE ASSISTANCE FUND	\$14,840.731	\$0	\$0	\$0	\$0
TOTAL RESERVE FUND POOL	\$41,721.835	\$0	\$0	\$0	\$0

UNALLOCATED FUND POOL-GME	\$0	\$0	\$0	\$0	\$0
UNALLOCATED FUND POOL-UNCOMPENSATED CARE	\$50,000.000	\$0	\$0	\$0	\$0
UNALLOCATED FUND POOL-EBNE	\$113,732.844	\$0	\$0	\$0	\$0
UNALLOCATED FUND POOL-FIRST THIRTY DAYS	\$23,562.436	\$0	\$0	\$0	\$0
SPECIAL POOL-MEDICAL EDUCATION	\$194,916.667	\$48,000.000	\$48,000.000	\$48,000.000	\$144,000.000
SPECIAL POOL-HOSPITALS	\$66,499.069	\$0	\$0	\$0	\$0

LONGTERM CARE -LEVEL I & II AND ICF MR	\$3,939,860.053	\$919,664.700	\$965,647.900	\$1,013,930.300	\$2,899,242.900
HCBS WAIVERS	\$299,159.139	\$151,243.600	\$158,805.800	\$166,746.100	\$476,795.500
MEDICARE COST SHARING AND PREMIUMS	\$933,055.763	\$216,992.700	\$227,842.300	\$239,234.400	\$684,069.400
ADMINISTRATION	\$515,603.998	\$127,848.400	\$132,962.300	\$138,280.800	\$399,091.500
ADMINISTRATION-CHIPS	\$3,257.578	\$4,441.200	\$4,663.300	\$4,896.500	\$14,001.000
REGULAR PROGRAM-PRIOR TO 1-1-94	\$887,567.643	\$0	\$0	\$0	\$0

TOTAL PROJECTED CASH EXPENDITURES	\$15,707,631.423	\$3,810,996.300	\$4,041,044.600	\$4,285,762.100	\$12,137,803.000
TOTAL CPE FEDERAL FUNDING	\$682,352.340	\$126,802.400	\$131,874.500	\$137,149.500	\$395,826.400
TOTAL EXPENDITURES/CPE FUNDING	\$16,389,983.763	\$3,937,798.700	\$4,172,919.100	\$4,422,911.600	\$12,533,629.400

FEDERAL FUNDING	\$10,664,851.783	\$2,473,707.300	\$2,611,584.500	\$2,737,011.500	\$7,822,303.300
FEDERAL FUNDING-CHIPS	\$39,660.939	\$57,175.100	\$60,030.900	\$63,032.500	\$180,238.500
PREMIUM REVENUE	\$113,640.443	\$35,000.000	\$36,750.000	\$38,587.500	\$110,337.500
PREMIUM REVENUE-CHIPS	\$5,077.700	\$5,077.700	\$5,128.500	\$5,179.800	\$15,386.000
OTHER REVENUE / CURRENT SERVICES	\$184,663	\$0	\$0	\$0	\$0
LOCAL GOVERNMENT	\$36,499.000	\$0	\$0	\$0	\$0
STATE TAX REVENUE	\$4,847,716.896	\$1,240,036.200	\$1,327,550.700	\$1,441,950.800	\$4,009,537.700
TOTAL FUNDING	\$15,707,631.423	\$3,810,996.300	\$4,041,044.600	\$4,285,762.100	\$12,137,803.000

05-May-98

## COMPARISON OF COST-TENNCARE

Estimated Final Expenditures FY 1993/94	Estimated Final Expenditures FY 1994/95	Estimated Final Expenditures FY 1995/96	Projected Expenditures FY 1996/97	Projected Expenditures FY 1997/98	TOTAL Expenditures Five Years
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## ELIGIBLES

985,566	1,240,861	1,220,000	1,170,000	1,220,000
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BASIC CAPITATION COST PRIOR TO BHO WAIVER

\$569,651,291	\$1,521,941,214	\$1,646,370,261	\$1,594,503,912	\$1,694,871,700	\$3,737,962,765
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BASIC CAPITATION COST AFTER TO BHO WAIVER

		\$0		\$38,557,257	\$3,289,375,612
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CAPITATION COST-BHO WAIVER

		\$0	\$250,726,870	\$327,746,770	\$578,473,640
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CAPITATION COST-BHO CHIPS

				\$7,455,178	\$7,455,178
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TOTAL CAPITATION COST PER YEAR

\$569,651,291	\$1,521,941,214	\$1,646,370,261	\$1,845,230,782	\$2,068,630,905	\$7,651,824,453
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SUPPLEMENTAL CAPITATION ADJUSTMENTS

					\$262,815,938
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1. SPMT THROUGH 6-30-96

\$51,097,207	\$106,836,707	\$104,882,024	\$0	\$99,121,400	\$508,930,457
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2A. CHILDRENS PLAN

\$48,419,400	\$144,836,664	\$113,335,993	\$103,217,000	\$4,073,550	\$4,073,550
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2B. CHILDRENS PLAN-CHIPS

			\$55,000,000	\$40,000,000	\$195,000,000
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3. HIGH COST CHRONIC CONDITIONS

\$20,000,000	\$40,000,000	\$40,000,000	\$8,300,000	\$7,750,000	\$16,050,000
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4. BHO/MENTAL HEALTH CLINIC POOL PAYMENTS)

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TOTAL CAPITATION CASH COST

\$689,167,898	\$1,813,614,585	\$1,904,589,278	\$2,011,747,782	\$2,219,575,855	\$8,638,694,398
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RESERVE FUND POOL

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1. PRIMARY CARE ASSISTANCE FUND

\$6,847,428	\$8,867,264	\$11,166,412	\$0	\$0	\$26,881,104
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2. MA/PRACTICE ASSISTANCE FUND

\$3,021,480	\$4,836,478	\$6,982,773	\$0	\$0	\$14,840,731
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TOTAL RESERVE FUND POOL

\$9,868,908	\$13,703,742	\$18,149,185	\$0	\$0	\$41,721,835
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UNALLOCATED FUND POOL-GME

\$50,000,000		\$0	\$0	\$0	\$50,000,000
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UNALLOCATED FUND POOL-UNCOMPENSATED CARE

\$66,856,021	\$46,876,823	\$0	\$0	\$0	\$113,732,844
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UNALLOCATED FUND POOL-EBNE

\$20,493,622	\$3,068,814	\$0	\$0	\$0	\$23,562,436
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UNALLOCATED FUND POOL-FIRST THIRTY DAYS

\$26,640,060	\$24,276,607	\$48,000,000	\$48,000,000	\$48,000,000	\$194,916,667
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SPECIAL POOL-MEDICAL EDUCATION

\$0	\$54,499,069	\$0	\$12,000,000	\$0	\$66,499,069
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SPECIAL POOL-HOSPITALS

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LONGTERM CARE -LEVEL I &amp; II AND ICF MR

\$660,424,699	\$724,098,000	\$813,438,937	\$860,173,417	\$881,725,000	\$3,939,860,053
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HCBS WAIVERS

\$18,249,151	\$25,569,140	\$50,325,824	\$71,657,224	\$133,357,800	\$299,159,139
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MEDICARE COST SHARING AND PREMIUMS

\$208,807,881	\$151,146,316	\$181,679,732	\$185,000,234	\$206,421,600	\$933,055,763
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ADMINISTRATION

\$93,734,915	\$86,240,794	\$101,630,552	\$110,705,337	\$123,292,400	\$515,603,998
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ADMINISTRATION-CHIPS

				\$3,257,578	\$3,257,578
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REGULAR PROGRAM-PRIOR TO 1-1-94

\$887,567,643	\$0	\$0	\$0	\$0	\$887,567,643
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TOTAL PROJECTED CASH EXPENDITURES

\$2,731,810,798	\$2,943,093,890	\$3,117,812,508	\$3,299,283,994	\$3,615,630,233	\$15,707,631,423
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TOTAL CPE FEDERAL FUNDING

\$49,667,733	\$133,221,120	\$176,540,815	\$179,573,570	\$143,349,101	\$682,352,340
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TOTAL EXPENDITURES/CPE FUNDING

\$2,781,478,531	\$3,076,315,010	\$3,294,353,323	\$3,478,857,564	\$3,758,979,334	\$16,389,983,763
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FEDERAL FUNDING

\$1,811,771,234	\$2,015,264,235	\$2,154,587,198	\$2,312,084,689	\$2,371,144,427	\$10,664,851,783
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FEDERAL FUNDING-CHIPS

	\$20,828,360	\$26,244,140	\$31,567,943	\$39,660,939	\$113,640,443
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PREMIUM REVENUE

				\$5,077,700	\$5,077,700
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PREMIUM REVENUE-CHIPS

				\$184,663	\$184,663
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OTHER REVENUE / CURRENT SERVICES

				\$0	\$0
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LOCAL GOVERNMENT

\$0	\$36,499,000	\$0	\$0	\$0	\$36,499,000
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STATE TAX REVENUE

\$920,039,564	\$870,502,295	\$936,946,507	\$955,481,362	\$1,164,747,167	\$4,847,716,895
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TOTAL FUNDING

\$2,731,810,798	\$2,943,093,890	\$3,117,812,508	\$3,299,283,994	\$3,615,630,233	\$15,707,631,423
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# **Attachment B**

## **MCO/BHO EPSDT Activities Report**

TENNCARE PARTNERS PROGRAM  
Service System Design  
Technical Advisory Group

Best Practices for Crisis Services

Revision Date: April 30, 1999  
**BEST PRACTICES FOR CRISIS SERVICES**

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## I. Preamble

As part of the TennCare Partners Program (TCPP)'s proposed Phase III program improvements, the Tennessee Department of Health (DOH) developed a series of Technical Advisory Groups (TAGs) to review several areas of program operations including: service system design, quality management, and financial review and information management.

The Service System Design TAG consisted of a broad range of representatives and key stakeholders in Tennessee including consumers, advocacy groups, family member/caregivers, providers, behavioral health organizations, state administrators and representatives from children's services, substance abuse services, adult protective services, and the Office of Minority Health.

Following a series of meetings with a range of TCPP stakeholders during the period June through August of 1998, the Tennessee Department of Health (DOH) identified crisis services as an initial priority task for the Service System Design TAG.

This report summarizes the recommendations of the TennCare Partners Program Service System Design Technical Advisory Group and is the outcome of a series of monthly meetings between September, 1998 and March of 1999.

The purpose of this document is to:

- (a) Summarize best practice standards for crisis services based on a literature survey of public sector mental health crisis response programs and national standards for behavioral healthcare related to the provision of crisis services; and,
- (b) Provide recommendations specific to delivery of crisis services within the TennCare Partners Program

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The SSD TAG views these recommendations as a blueprint for current best practices in the field of crisis response services and as a guide for future development of crisis services in Tennessee. In addition, this report is an educational tool which, it is hoped, will set in motion a continuing dialogue between consumers, family member/caregivers and providers as to the essential role of effective crisis services in a behavioral healthcare delivery system.

Section III: **"Best Practice Elements for a Crisis Response System"** provides a summary of best practice standards for crisis services.

Sections IV, V, VI, VII and VIII: **Policies and Procedures; Essential Program Components of an Effective Crisis Service System; Staffing, Organization and Reporting Structure; Training and Credentialing of Staff; and, Documentation and Record-Keeping** provide a detailed view of operational guidelines for crisis service programs.

It should be noted that services and program components discussed in this report under Section IV: **Essential Program Components of an Effective Crisis Service System** are based on a review of the literature. This section includes both services currently mandated under the TennCare Partners Program (TCPP) BHO contract and other service components not mandated as covered services within the TCPP contract.

The final Section IX: **"Recommendations"** includes specific recommendations as to proposed changes in TCPP/BHO contract provisions.

## II. Definitions

For the purposes of clarifying terms in this document the following definitions related to mental health crises are discussed:

- Mental Health Crisis
- Urgent Condition
- Emergency

A "Mental Health Crisis" is defined as a "serious disruption in the individual's normal level of daily functioning"... which "may be precipitated by an acute exacerbation of a psychiatric illness", a "problem related to medication, or environmental stresses". Crises are "created by a combination of factors related to a psychiatric illness and factors related to inadequate social, economic, and emotional supports. As a result, crises often contain both clinical and social or environmental elements."

In addition to agreeing on the definition of certain terms, it is important to understand the nature of mental health crises and some differentiating factors between adult and child/adolescent crises.

The following discussion on the nature of crises serves to highlight some of the differences between adult and child/family crises in terms of the preponderance of "psychosocial" versus psychiatric or clinical features:

"The onset of a crisis can be produced by psychological, social, physiological or environmental factors, or a combination of these forces. Individuals can experience a crisis in response to events in the life cycle, such as a change in family structure, or in response to developmental changes and stresses. Some events may be a part of the normal course of living and others may be of a more extreme nature, such as the death of a parent for a child or adolescent. Some children and families move from

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<sup>1</sup> Stroul, B., Crisis Residential Services in a Community Support System, NIMH, 1987, Page 7.

crisis to crisis because of chaotic lives marked by poverty, poor health, and other social stresses. Some children are in crisis because they are victims of violence, abuse, and neglect."

While a crisis may not necessarily meet the definition of an emergency in terms of constituting an immediate "substantial likelihood of harm to self or others", it is assumed that if left untreated a crisis is likely to deteriorate into a bone fide emergency.

For the purposes of this document, the following definitions apply:

An "*Emergency*" is defined in the TennCare Partners Program (TCPP) contract as follows:

"An acute onset of a psychiatric condition that manifests itself by an immediate substantial likelihood of serious harm to self or others".

It is recommended that an "*Urgent Condition*" be specifically defined within the TCPP contract as:

"An acute onset of a psychiatric condition which while not constituting an immediate substantial likelihood of harm to self or others will if left untreated deteriorate into a bona fide emergency."

A "*Mental Health Crisis*" is defined as follows:

"An urgent condition or an emergency which involves a significant and serious disruption in an individual's normal level of functioning due to an acute exacerbation of a psychiatric illness precipitated by psychosocial factors such as a high level of environmental stressors and/or inadequate social, economic or emotional supports."

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<sup>2</sup> Goldman, Sybil K., Series on Community-based Services for Children and Adolescents Who Are Severely Emotionally Disturbed: Volume II Crisis Services, NIMH, 1988.

### III. Best Practice Elements for a Crisis Response System



1. Develop Clear Lines of Accountability.

Develop clear lines of responsibility and accountability for all crisis services whether operated within other community mental health services or provided through an independent agency.



2. Organize a System of Care.

Recognize need to develop a "system of care" approach in order for crisis services to be effective.

- Identify other agencies and services that impact crisis services.
- Develop formal written affiliation agreements with providers and agencies.
- Participate regularly in joint committee meetings with key agencies including law enforcement, MH/MR services, adult protective services, alcohol and drug programs and agencies, juvenile justice, child welfare programs, and agencies serving the aging and individuals with disabilities.



3. Assure Access to a Continuum of Services.

Recognize the need for a full continuum of services without which individual crisis services will have limited effectiveness. A continuum of crisis services includes, but is not limited to the following services:

- urgent outpatient care services

- medication management
- case management
- crisis residential services including:
  - respite care
  - respite apartments
  - home-based crisis services
  - group home crisis services
- partial hospital-based crisis services
- acute hospital-based crisis services



4. **Develop Child/Adolescent and Family-focused Crisis Services.**

- Prioritize the development of child/adolescent centered and family focused crisis services. Require the participation of clinicians who provide child/adolescent and crisis services to have specific credentials and training in providing crisis services to children and adolescents.
- Prioritize cross training of all staff in child/family crisis services.

Resource allocations between adult and child services should ultimately reflect the true demand for crisis services within the community. In principle, there should be an equitable division of resources between adult and child/family/caregiver crisis services. Most importantly, local programs must assure utilization of trained and credentialed child/adolescent clinicians in providing crisis services to children and adolescents.

As a minimum standard, individual crisis response services should ensure the availability of at least one designated child specialist on each Crisis Team, with 24-hour availability of a child specialist. Cross training of all crisis staff in child/family

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crisis services should be a program priority.<sup>1</sup>

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<sup>1</sup> It should be noted that Service System Design TAG Committee members identified different models for crisis services based on "traditional psychiatric emergency services" versus "psychosocial and community based" approaches which could not entirely be reconciled.



5. **Provide Education and Outreach.**

Prioritize the development of a comprehensive education and outreach program within each community providing crisis services. Heighten community awareness through communication and outreach to local community service agencies and providers. Focus communication efforts on under-utilizers of crisis services. Develop a communication strategy that recognizes the need to reach populations with limited literacy or communication difficulties.

At a statewide level, behavioral health organizations should provide provider network training and member education relevant to access to and utilization of crisis and emergency services. Behavioral health organizations and mental health agencies should collaborate to identify opportunities for inter-agency education, coordination and formal inter-agency agreements that would promote the appropriate utilization of mental health crisis services.



6. **Prioritize Consumer and Family Member/Caregiver Involvement.**

Local crisis programs must prioritize the direct involvement of consumers and family members/care givers in the development of post emergency service planning and community resource identification and coordination. For example: (i) develop mentoring programs provided by consumers and family members, and (ii) develop programs involving direct consumer involvement in crisis services or as adjunct support staff.



7. **Improve Access for Consumers with Mental Health and Substance Abuse and/or Mental Retardation Diagnoses.**

Eliminate barriers to providing services to dually diagnosed consumers (mental health/ substance abuse or mental health/mental retardation) by reassessing service standards and requirements. At a minimum, crisis services should consider revising policies that automatically rule out services to drug or alcohol involved consumers when such services can be provided safely and effectively. Local crisis programs must eliminate barriers to serving consumers who have a mental illness and coexisting substance abuse diagnosis or a mental illness and mental retardation. Policies should be established outlining specific service standards for appropriate coordination with other agencies serving these consumers so that there are no gaps in services provided.



8. **Measure Consumer and Family Member/Caregiver Satisfaction.**

Develop satisfaction surveys for consumers, family members/caregivers, and providers/agencies on at least a semi-annual basis. Programs should send out member satisfaction surveys 30-60 days post service or utilize consumer and family member/caregiver focus groups to determine satisfaction with services. Surveys should focus on responses from individuals with severe mental illness.



9. **Develop Performance Monitoring Standards.**

Develop clear standards for monitoring crisis services based on clearly articulated values and principles including the need for follow-up and continuing services to consumers after

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initial crisis services are provided. Make staff accountable for follow-up and monitoring activities. Make the Director of Service accountable for tracking and monitoring all consumers as well as collecting and reporting outcome data. Develop outcomes and reporting data based on a longitudinal view of services and consumer outcomes.



10. **Develop System-Wide Cultural Competence in Crisis Services.**

Assure that cultural and linguistic competence is the guiding principle around which all crisis services are structured including the administration, design and delivery of all services.

#### IV. Policies and Procedures<sup>4</sup>

Crisis Services providers should develop the following program materials:

1. Program Description. A written description of the Crisis Services program in clear and understandable language must be available to staff, consumers, and members of the public. The description should include at least the following:
  - Service components and functions.
  - Services offered, availability of staff (including psychiatric and medical backup) to provide services, and hours of operation.
  - Characteristics of persons to be served, specifying ages of consumers served.
  - The referral process including active linking to referral agencies.
  - The duration of services to be provided and the minimum level of post crisis follow-up.
  - A summary of formal written affiliation agreements with other providers and agencies involved in crisis services.
  - The service area.
  - Guarantees of access to crisis services without regard to ability to pay.
2. Quality Improvement Plan. A quality improvement program that identifies specific procedures to assess the quality of care provided to consumers. This program must ensure appropriate intervention has been delivered according to acceptable clinical practices and that services are accessible based upon telephone

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<sup>4</sup> Adapted in part from "Minimum Requirements for Mental Health Crisis Response Services, TCPP (Draft)"

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response times, mobile response times, and collection of follow-up outcome and satisfaction data from consumers, family members/caregivers, and selected providers/referral agencies. The designated Crisis Services Director shall be responsible of assuring the effectiveness of the Crisis Services Quality Improvement Plan.

3. Managing Risk of Homicide or Suicide (also refer to "Documentation and Record-Keeping" Section for Risk Assessment guidelines)

A written policy specifying procedures for managing risks posed by acutely homicidal or suicidal consumers including:

- What actions must be taken to minimize any physical harm to the consumer, staff or others; and,
- Identifying respective roles and responsibilities of law enforcement and crisis staff.

4. Consumer and Staff Safety

Provisions for consumer and staff safety must be addressed in policies and procedures for the following conditions:

- Office-based services
- Out of office situations which pose a danger (e.g. verbal threats or use of a weapon);
- Home and community interventions; and,
- Vehicle operations with a consumer in the vehicle.

5. Emergency Medical Procedures.

In addition to the above, there should be written emergency procedures that include<sup>5</sup>:

- Screening for general medical conditions

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<sup>5</sup> Adopted from 1998 CARF Behavioral Health Standards Manual

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- Coordination agreements with general medical and emergency care providers
  - Making referrals for emergency medical services when indicated
  - Identifying personnel trained in emergency procedures
  - When appropriate, identifying personnel other than physicians who can perform special procedures, including:
    - The circumstances under which non-physicians can perform these procedures
    - The degree of supervision required to perform these procedures
    - Handling standing orders

#### 6. Accessibility

A policy and specific procedures which describe accessibility to services and include the following elements:

- Access via a toll free telephone number
- Adequate telephone response systems staffed by specially trained clinical personnel.
- Standard: Crisis telephone calls must be responded to 24 hours a day, 7 days a week by a staff member trained in crisis counseling (not by an answering service, voice mail recording or other mechanical device).
- When determined to be appropriate, face-to-face Crisis Services are provided within one hour of the initial consumer telephone contact. - Each program should implement a standard specifying the conditions under which a face-to-face contact is appropriate with specific standards for children and adolescents.

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- The identified crisis program director shall be directly responsible for maintaining procedures to monitor and document and report response times, and to evaluate and correct response related problems in a timely manner.

## 7. Scope of Crisis Services.

The Crisis Services Program shall maintain written policies that address each of the following components:

- The development of child/adolescent centered and family focused crisis services. Assure utilization of specialized child/adolescent clinicians in providing crisis services to children and adolescents and prioritize cross training of all staff in child/family crisis services.
- The development of a comprehensive education and outreach program on crisis services within each community. The goal of education is to heighten community awareness through communication and outreach to local community service agencies and providers. The focus of outreach and communication efforts should be populations who historically under-utilize mental health crisis services due to educational, cultural and other factors.
- The direct involvement of consumers, family members/ caregivers and significant others in both the development of post-emergency service planning and community resource development. In addition, the development mentoring programs provided by consumers and family members should be prioritized with the goal of direct consumer involvement in crisis services or as adjunct support staff.
- Provision of services to consumers with a mental illness and substance abuse diagnosis, as well as consumers with MH/MR

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diagnoses. Policies that automatically rule out services to drug or alcohol involved consumers or other populations (MH/MR), when such services can be provided safely and effectively, should be revised.

- Crisis Services provide culturally appropriate services and are responsive to the linguistic, cultural and communication needs of the population in the crisis service area both in terms of staffing, training and procedures for arranging for access to culturally competent staff. Where there are deficits in the cultural capability of staff or referral agencies and providers, a plan for addressing the development of appropriate resources is outlined.

#### 8. Risk Management Procedures

Procedures which address methods, documentation and reporting of the occurrence or allegation of physical, verbal, sexual abuse, or injury or any other adverse incident involving consumers.

#### 9. Transportation

Procedures regarding emergency and non-emergency transportation of consumers, including documentation of the transportation plan from each county served. It should also be noted that the BHOs are responsible for providing non-emergency transportation to covered services when the enrollee lacks access to transportation (*Statutory reference: TCA 33-6-103*).

#### 10. Referral and Coordination

Policies and procedures regarding referral and coordination mechanisms (including responsibility for transportation when required) for services outside of the program, including but not limited to:

- Law enforcement

- Health maintenance organizations or other medical treatment providers
- Hospitals and emergency rooms (pertaining to physical and psychiatric situations), including but not limited to admission process, medical screenings; detoxification needs
- Mental health providers of consumers being served by the Crisis Service
- Other agencies specifically including alcohol and other drug treatment providers, social service agencies, adult protective services, schools, child welfare and juvenile justice system agencies.
- Agencies serving older people.

## 11. Consumers Rights

Policies and procedures which assure provider compliance with consumer rights, including but not limited to consumer choice and confidentiality as provided by state and federal statute. (*Reference*)

## 12. Program Monitoring and Consumer Tracking

Policies and procedures that delineate clear standards for monitoring crisis services must be available. Procedures must include provisions for assessing the need for continuing care, the referral process, and tracking follow-up after initial crisis services are provided. Procedures must also identify staff who are accountable for follow-up and monitoring activities. Policies should support the direct involvement of the consumer in meetings with continuing care providers/agencies whenever possible. The Director of the Crisis Service shall be accountable for tracking and monitoring all consumers as well as collecting and reporting outcome data.

## V. Essential Program Components of an Effective Crisis Service System

### OVERVIEW

Crisis response systems should be viewed as one component of a comprehensive community support system designed with the following goals<sup>6</sup>:

- To rapidly stabilize individuals in crisis and avert the need for more intensive, restrictive services.
- To assist individuals who experience a psychiatric crisis in resuming their pre-crisis level of functioning as rapidly as possible by utilizing natural support systems.
- To link consumers and family members/caregivers to ongoing services and supports within the community.

### Crisis Services as a Part of a Continuum of Services

In order to be effective crisis response systems must operate within a continuum of community-based services. This full continuum of services should include: urgent outpatient care services, medication management, case management, consumer and family member support services, rehabilitation services, housing, substance abuse treatment services, residential treatment, therapeutic foster care, respite care, in-home services and acute hospital-based emergency services. Without an appropriate and comprehensive continuum of mental health services, crisis services will have limited effectiveness.

### System of Care Approach

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<sup>6</sup>Stroul, B., Psychiatric Crisis Response Systems: A Descriptive Study, CMHS, 1986.

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A system of care approach is essential in providing effective crisis services for all populations and especially for children, their families/care givers. A system of care approach is based upon a model in which mental health services are viewed as one component of a coordinated, comprehensive multi-dimensional network of social, educational, vocational, recreational, housing, and health services.

Crisis services must operate with an understanding of other agencies and service systems that impact consumers' utilization of crisis services. Specifically, this entails specifying program policies and procedures for establishing effective linkage with other service systems; developing formal written affiliation agreements with providers and agencies; and participation regularly in joint meetings with key agencies including law enforcement, MH/MR services, substance abuse, housing, juvenile justice, schools, and child welfare programs.

## GENERAL PROGRAM COMPONENTS

### Crisis Telephone Service

A crisis telephone service operates 24 hours a day, 7 days per week utilizing personnel specifically trained in crisis services. Crisis telephone services must be toll-free and answered immediately by a staff member trained in crisis counseling, and knowledgeable about community mental health services, support groups, and other services for crisis resolution.

Crisis telephone services have the capability of providing an immediate telephone screening, assessing the risk for suicide or substantial likelihood of harm to self or others, developing an intervention plan, and determining the appropriateness of face-to-face crisis services or other emergency services. Secretaries, receptionists, or answering services should not be the first line of response for crisis calls. Volunteers should never be utilized to provide telephone crisis services.

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All crisis service staff should operate under the supervision of licensed clinicians with specialized training in crisis intervention and crisis services. (See Section on "Training and Credentialing of Staff")

## SPECIALIZED PROGRAM COMPONENTS FOR CHILDREN AND ADOLESCENTS

A psychiatrist trained and credentialed in the assessment and treatment of children and adolescents should be on-call whenever considerations of medication, emergency general medical/ psychiatric services or special risks to the consumer require medical back up.

### Walk-In Crisis Services

Walk-in crisis services provide an immediate screening and assessment, crisis intervention and stabilization function as part of an overall outpatient emergency service system (which would include mental health case management, medication management, and urgent outpatient appointments).

Other functions provided to consumers include:

- Education on how to prevent or manage a crisis
- Identification of natural support systems
- Work with the consumer's family/caregiver with consumer's consent (unless contraindicated)
- Development of a crisis plan
- Provision of 24 hour availability of mental health services to an on-going consumer
- Coordination with emergency personnel regarding an on-going consumer
- Make available appointments for urgent needs
- Make available emergency and urgent appointments for medication evaluation
- Referral and active linkage to ongoing services, including mental health and other community-based services
- Referral to more intensive levels of treatment such as acute hospital care when appropriate

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All crisis service staff should operate under the supervision of licensed clinicians with specialized training in crisis intervention and crisis services. Mobile crisis staff should have access to a trained clinical supervisor at all times. An appropriately trained and credentialed psychiatrist should be on-call whenever considerations of medication, emergency general medical/psychiatric services or special risks to the consumer require medical back up.

#### SPECIALIZED PROGRAM COMPONENTS FOR CHILDREN AND ADOLESCENTS

A psychiatrist trained and credentialed in the assessment and treatment of children and adolescents should be on-call whenever considerations of medication, emergency general medical/ psychiatric services or special risks to the consumer require medical back up.

(See Section on "Training and Credentialing of Staff")

#### Mobile Crisis Services

The goal of mobile outreach services is to provide crisis intervention services in natural environments including the consumer's home and other accessible, appropriate locations in the community. Mobile outreach services are provided in an effort to reach persons who may have physical limitations or who are unable or unwilling to utilize traditional office-based services.

The goal of mobile services is to provide proactive services in the most normalized community setting possible to mobilize intensive treatment resources and to assist families/caregivers and consumers in coping with the disturbing behavior of a family member to reduce the likelihood of utilization of more restrictive treatment alternatives.

All crisis service staff should operate under the supervision of licensed clinicians with specialized training in crisis intervention and crisis services with children and adolescents. Mobile crisis staff should have

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access to a trained and credentialed licensed clinical supervisor at all times.

### SPECIALIZED PROGRAM COMPONENTS FOR CHILDREN AND ADOLESCENTS

A comprehensive system of care approach is particularly important to the effective provision of crisis services to children and adolescents. Formal affiliation agreements with school systems, child welfare and juvenile justice agencies are critically important to the provision of effective crisis services to children and adolescents. It is recommended that interagency linkages be maintained through ongoing involvement in interagency committees at the local and regional level.

The goal of mobile outreach services is to provide crisis intervention services in natural environments including the consumer's home and other accessible, appropriate locations in the community. Mobile outreach services are provided in an effort to assist families/caregivers in crisis related to the behavioral problems of a child or adolescent family member.

As a minimum standard, individual crisis response services should ensure the availability of at least one designated child specialist on each Crisis Team, with 24-hour availability of a child specialist. Cross training of all crisis staff in child/family crisis services should be a program priority.<sup>7</sup>

A psychiatrist trained and credentialed in the assessment and treatment of children and adolescents should be on-call whenever considerations of medication, emergency general medical/ psychiatric services or special risks to the consumer require medical back up.

### Crisis Residential Services

A comprehensive crisis service should offer linkages to a variety of

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<sup>7</sup> It should be noted that Service System Design TAG Committee members identified different models for crisis services based on "traditional psychiatric emergency services" versus "psychosocial and community based" approaches which could not entirely be reconciled.

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residential alternatives for stabilizing and maintaining consumers who require short-term respite in a safe, secure supervised 24-hour environment outside a hospital setting. Crisis residential services may include any of the following types of programs: group crisis residences, crisis beds in longer-term programs, family-based crisis homes, crisis apartments, consumer respite programs, and facility based crisis stabilization unit.

Licensed nursing personnel should be available on-site or on-call 24 hours a day, 7 days a week.

Crisis residential staff should have access to a trained licensed clinical supervisor at all times. An appropriately trained and credentialed psychiatrist should be on-call whenever considerations of medication, medical emergency/psychiatric services or special risks to the consumer require medical back up.

#### SPECIALIZED PROGRAM COMPONENTS FOR CHILDREN AND ADOLESCENTS

These services involve the following specialized programming: family-based crisis homes, crisis respite for parents/family members/caregivers, facility-based crisis respite care, emergency shelter, emergency foster care, crisis nursery, and family preservation programs.

Clinical staff with specialized training in services for children and adolescents should be utilized. Licensed nursing personnel should be available on-site or on-call 24 hours a day, 7 days a week.

A focus of crisis intervention for children and adolescents should involve family/caregiver oriented interventions to clarify and stabilize the crisis as well as assisting the family in developing alternative coping skills. In addition, family members/caregivers should be involved in joint meetings with both crisis staff and treatment personnel who will be providing ongoing services.

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Crisis residential staff should have access to a trained and credentialed licensed clinical supervisor (either on-site or on-call) at all times.

A psychiatrist trained and credentialed in the assessment and treatment of children and adolescents should be on-call whenever considerations of medication, general medical emergency/psychiatric services or special risks to the consumer require medical back up.

## Hospital-based Crisis Services

Crisis services should utilize hospital emergency room services or other acute psychiatric services as appropriate based on the assessment of risk to the consumer and the need for a medically supervised setting. Typically these services are provided through a contractual or affiliation agreement with a public or private community-based hospital. Psychiatric crisis services may be provided either in freestanding psychiatric programs or within psychiatric units in general hospitals. Agreements with hospitals that provide inpatient psychiatric crisis services should include\*:

- Clearly defined procedures and roles for screening, admission, consultation and information-sharing between mental health and hospital staff
- Provisions regarding the use of hospital emergency room space
- Procedures for obtaining medical screening and clearance by hospital staff
- Procedures for managing referrals between emergency room and mental health staff
- Provisions for on-site or on-call coverage
- Agreements as to sharing of staff (when applicable)

Acute hospital-based crisis services should be utilized for consumers who cannot be managed in a less restrictive setting because of a clear danger to self or others, grave disability, or the presence of a medical condition which constitutes a medical emergency due to the patient's unstable

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\* Adopted from: B Stroul: Psychiatric Crisis Response Systems: A Descriptive Study, 1993.

condition.

#### SPECIALIZED PROGRAM COMPONENTS FOR CHILDREN AND ADOLESCENTS

A psychiatrist trained and credentialed in the assessment and treatment of children and adolescents should be on-call whenever considerations of medication, general medical emergency/psychiatric services or special risks to the consumer require medical back up.

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## VI. Staffing, Organization and Reporting Structure

1. The crisis service must be staffed to provide service seven days per week, 24 hours per day.
2. The crisis service must have a designated program director or administrator who is responsible for the management and operation of the program. The program director or administrator must be responsible for direct supervision of staff, administration of quality improvement and risk management programs, monitoring and tracking consumer follow-up and outcomes, maintaining documentation and record-keeping, and providing required reports as well as performing other administrative and clinical functions.
3. Staff available must be qualified to execute an emergency hospitalization certificate of need. Training for those designated to complete certificates for involuntary hospitalization shall be consistent with requirements set forth in T.C.A. 33-6-103.
4. The crisis service must have sufficient number of staff to permit response times in compliance with program policy.
5. The crisis service must have a licensed psychiatrist available for consultation seven (7) days per week, 24 hours per day. (and when appropriate, a licensed psychiatrist specializing in children and adolescents.)
6. Mental health personnel must be supervised by a licensed mental health professional. Clinical supervision of all staff must be provided by a mental health professional with at least a Master's level license at a level that allows for independent clinical practice.

## VI. Training and Credentialing of Staff<sup>9</sup>

The service provider must ensure that all staff providing direct clinical services has the necessary skills and training needed to meet program standards.

### A. MINIMUM CREDENTIALING OF CRISIS SERVICE STAFF

#### 1. Telephone-based Crisis Services

The first level of response to crisis/emergency callers should be provided by a mental health professional with specialized training in crisis intervention with a minimum of a bachelor's degree in a related field of counseling, psychology or social work. Preferably, whenever possible, telephone response should be provided by a masters level licensed clinician. Staff providing crisis telephone services should be under the direct supervision of a licensed mental health clinician at all times. An appropriately trained and licensed psychiatrist should be available for backup.

Volunteers or student interns should never be used to provide telephone-based crisis services.

#### STANDARDS SPECIFIC TO PROVISION OF CHILD/ADOLESCENT SERVICES

As a minimum standard, individual crisis response services should ensure the availability of at least one designated child specialist on each Crisis Team, with 24-hour availability of a child specialist. Cross training of all crisis staff in child/family crisis services should be a program priority.

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<sup>9</sup> Adapted from "Minimum Program Requirements for Mental Health Crisis Response Services, TCPP"

## 2. Walk-in Crisis Services

The first level of response to crisis/emergency consumers seeking on-site appointments should be provided by a mental health professional with specialized training in crisis intervention with a minimum of a master's degree in a related field of counseling, psychology or social work. Preferably, whenever possible, service should be provided by a master's level licensed clinician.

## 3. Mobile Crisis Services

The first level of response to crisis/emergency consumers receiving mobile crisis services should be provided by a mental health professional with specialized training in crisis intervention with a minimum of a master's degree in a related field of counseling or social work. Preferably, whenever possible, services should be provided by a masters level licensed clinician.

All crisis service staff should operate under the supervision of licensed mental health professionals with specialized training in crisis intervention and crisis services. Mobile crisis staff should have access to an appropriately trained and credentialed licensed clinical supervisor at all times.

An appropriately trained and credentialed psychiatrist should be on-call whenever considerations of medication, emergency general medical/psychiatric services or special risks to the consumer require medical back up.

STANDARDS SPECIFIC TO PROVISION OF CHILD/ADOLESCENT SERVICES

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A licensed psychiatrist with specialized training with children and adolescents should be available to consult on services to children and adolescents.

## **B. STAFF TRAINING AND DEVELOPMENT**

Training shall be provided to all new staff through a comprehensive orientation program and on-going training/education to assist staff in the performance of their duties. Staff development shall be provided to all employees on a regular basis for at least eight (16) hours a year. This training may include workshops or conferences, as well as in-service education provided by the agency.

Crisis services staff must have competence in providing services to the following populations:

- (a) Consumers with diagnoses of both mental illness and mental retardation
- (b) Children and youth
- (c) Geriatric Consumers
- (d) Consumers with diagnoses of both mental illness and substance abuse
- (e) Individuals who are deaf or hard of hearing

Curriculum should include at least the following topic areas:

- (a) Diagnosis, etiology, treatment of mental illness and alcohol and other drug abuse

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- (b) Medications, medication management and medication assessment
  - (a) Crisis assessment
  - (c) De-escalation of crisis situations
  - (d) Management of assaultive/homicidal consumers
  - (e) Interactions with law enforcement
  - (f) Interactions with emergency room personnel
  - (g) Crisis intervention and resolution including safety procedures
  - (h) Assessment of suicidal risk
  - (i) Consumer and family perspectives
  - (j) Special procedures for working with children, adolescents and families, and geriatric consumers
  - (k) Agency policies and procedures including quality management and record keeping

### C. OUTREACH AND TRAINING FOR OTHER COMMUNITY AGENCIES

In order to effectively coordinate with other community based services, the Crisis Service Program should provide regular opportunities for outreach and training of other community service providers essential to the effective administration of crisis and emergency services including:

- (a) Police/sheriff and law enforcement personnel
- (b) Hospital emergency room staff
- (c) Alcohol and drug agency staff
- (d) State hospital personnel
- (e) Courts
- (f) Juvenile Justice system
- (g) Child welfare system
- (h) Adult protective services
- (i) Agencies focusing on aging.

## VII. Documentation and Record-keeping

### STANDARDS FOR DOCUMENTATION FOR ALL CONSUMER CONTACTS

All calls (whether or not services are provided) must be documented including time and date of call, nature of crisis, action taken, and recommended follow-up services.

For telephone contacts, an individual record must be maintained including the following information:

- Name, address, telephone number of consumer; (parent, guardian and/or custodian, if a minor), and emergency contact person.
- Demographic information
- Type of contact
- Location, time of initial consumer contact, time of crisis service response, reason for contact and total direct contact time with consumer
- Referral source
- Notification of patient rights and informed consent procedures must be documented.
- Clinical assessment including specifically an assessment of risk (see below)
- Summary of any clinical interventions
- Disposition
- Follow-up and outcome

The consumer record must include all follow-up contacts and pertinent outcome information as to the consumer's clinical and psychosocial status.

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Records must be maintained under applicable state and federal laws and regulations.

## STANDARDS FOR DOCUMENTATION OF CLINICAL ASSESSMENTS

1. The Crisis Service must screen and identify the most appropriate response for individuals in crisis by determining the following information:
  - (a) Level of crisis (urgent, emergency )
  - (b) Degree of safety risk to individual, staff, others
  - (c) Type of response indicated (phone or face-to-face, on-site or off-site contact)
  - (d) Type of intervention needed
  - (e) Need for medical screening
  
2. The Crisis Response Assessment shall contain the following documentation elements:
  - (a) Current presenting problem
  - (b) Relevant past psychiatric treatment history/psychological evaluations, if known; including knowledge of all current mental health providers.
  - (c) Medication assessment including current psychotropic medications, dose, start date and medication compliance, or non-compliance
  - (d) Assessment of alcohol and drug involvement
  - (e) Health and mental status and medical problems; independent functioning including activities of daily living and independent daily living skills
  - (f) Psychosocial supports

## DOCUMENTATION REQUIREMENTS SPECIFIC TO CHILDREN AND ADOLESCENTS

In addition all documentation related to children or adolescents<sup>10</sup>: should consider the following information:

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<sup>10</sup> Adapted from 1998 CARF Behavioral Health Standards Manual

- Developmental history, such as developmental age factors, motor development and functioning
  - School history
  - Speech, hearing, and language functioning
  - Visual functioning
  - Health status
  - Learning ability
  - Intellectual functioning
- Custody status, including recent changes in placement; stability of current placement; assessment of stability of current caregivers including presence of mental disorder or substance abuse in parent/caregiver.
  - Significant loss or illness of parent/ caregiver.

### 3. Risk Assessment<sup>11</sup>:

The Crisis Service must develop a structured protocol for evaluating consumer risk. Crisis response staff must complete a comprehensive and structured clinical risk assessment for all telephone or face-to-face crisis contacts based on this risk assessment protocol. A structured risk assessment should take into consideration the following risk factors:

- Presence of Affective Disorder

Sustained sense of hopelessness

Significant agitation or psychomotor retardation

- History of substance abuse or dependence

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<sup>11</sup> Sources: Taylor, M, Sierles, F. and Abrams, R. General Hospital Psychiatry, Free Press, 1985.  
Sederer, L and Rothschild, A.J. (Eds.), Acute Care Psychiatry: Diagnosis and Treatment, Williams & Wilkins, 1997.

Type of substances, pattern of use, route of administration, previous treatment attempts

Current intoxication and/or pattern of abuse of drugs and/or alcohol.

- History of suicide attempts

Consumer history of previous suicide attempts

History of suicide in biological family or close relationships

A specific intent and plan to harm self or others.

The means to harm self or others

- History of violent behavior

History of reckless, impulsive acting out behavior or loss of control

History of physical and/or sexual abuse

Recent family concern expressed about risk of dangerous behavior.

Pending legal issues

- Concomitant medical illness

Serious systemic illness, especially chronic or painful medical condition

- Treatment compliance

History of missed appointments, medication noncompliance and/other evidence of poor compliance with treatment.

- Level of psychosocial supports
- Current stressors including loss of employment, financial difficulties, legal issues, major losses, etc.
- Other demographic factors associated with high risk for suicide (single, widowed, divorced or separated, etc.)

## RISK FACTORS SPECIFIC TO CHILDREN AND ADOLESCENTS

- Imminent risk of out-of-home placement; recent changes in placement; or, stability of current placement
- Child exhibits multiple needs and problems requiring services from more than one agency including<sup>12</sup>:
  - (a) Serious impairment in functioning over the past three months
  - (b) History of, or at imminent risk of, school expulsion, suspension, or alternative placement
  - (c) History of learning disability or developmental disability requiring special services from school system
  - (d) Serious illness of a chronic or life-threatening nature
  - (e) History of suicide threats or self-injurious behavior
  - (f) Involvement with juvenile justice system
  - (g) Experience with extreme community violence, trauma or natural disaster
  - (h) History of multiple out of home placements
- Presence of mental illness or active substance abuse in parent/caregiver.
- Recent loss in parent/caregiver due to illness, death, or any other reason.
- History of child abuse or neglect including abandonment or exploitation of child.
- Family/caregiver experiencing extreme stress.

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<sup>12</sup> Adapted from "Life Domains Assessment Categories for Children and Youth", September 24, 1998 Draft, Bureau of TennCare.

## IX. Recommendations

- A. Assure that the TennCare Partners Program provides an effective urgent outpatient care system that can respond to consumers and family members in crisis who require urgent services.

Rationale: An effective crisis response system depends upon the availability of an array of urgent outpatient care services. In order to be effective, a crisis response system must operate within a continuum of community-based services. Without an appropriate and comprehensive continuum of mental health services including specifically the availability of outpatient urgent care services, crisis services will have limited effectiveness.

- A-1 Enforce current contract mandates requiring provision of urgent care to active consumers.

Rationale: Enforcement of existing contract language which mandates the provision of services for urgent conditions will greatly enhance system responsiveness to crises and thereby reduce unnecessary or inappropriate hospital admissions. Patients discharged from the hospital will receive timely and appropriate outpatient services particularly as regards medication and medication monitoring.

Contract Reference: Attachment B: Covered Mental Health and Substance Abuse Services: Service Type-Outpatient Mental Health Services:

M.D. Services: "Response time to contact an active consumer in an urgent situation- Within 4 hours; if medication related, within 1 hour.

Non-M.D. Services: "Response time to contact an active consumer in an urgent situation- Within 4 hours; if medication related, within 1 hour.

A-2            Develop a clear contractual definition for an "Urgent Condition" and specifically include "Mental Health Crisis" as an "Urgent Condition" or an "Emergency".<sup>13</sup>

Rationale: Access and performance standards for urgent care are already defined within the TennCare Partners Program Contract under Attachment B. By defining a Mental Health Crisis as falling within the parameters of an "Urgent Condition", contract mandates will be clearly extended to the provision of crisis services.

A "*Mental Health Crisis*" should be defined as follows:

"An urgent condition or an emergency which involves a significant and serious disruption in an individual's normal level of functioning due to an acute exacerbation of a psychiatric illness precipitated by psychosocial factors such as a high level of environmental stressors and/or inadequate social, economic or emotional supports."<sup>14</sup>

An "*Emergency*" is defined in the TennCare Partners Program Contract as follows:

"An acute onset of a psychiatric condition that manifests itself by an immediate substantial likelihood of serious harm to self or others".

An "*Urgent Condition*" should be specifically defined within the TCPP contract as:

"An acute onset of a psychiatric condition which while not constituting an immediate substantial likelihood of harm to self or others will if left untreated deteriorate into a bona fide emergency."

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<sup>13</sup> This recommendation is based on current contract language and is subject to change based on TCA code changes or adoption of new contract language consistent with NCQA Standards.

<sup>14</sup> <sup>14</sup>Stroul, B., Crisis Residential Services in a Community Support System, NIMH, 1987.

- A-3      The TennCare Partner's Program contract should include specific language indicating that a Mental Health Crisis or Emergency Services will be covered when a "prudent layperson, acting reasonably, would have believed an emergency or crisis existed."

Rationale: This language would eliminate concerns about appropriate responses to crisis situations. It is consistent with 1999-2000 NCQA Managed Behavioral Healthcare Organization Standards, which proposes the following standard:

"The organization covers any emergency services necessary to screen and stabilize members without precertification [prior authorization<sup>15</sup>] of emergency services in cases where a prudent layperson, acting reasonably, would have believed that an emergency existed."

- B.      Crisis teams must be required to meet all TennCare/BHO contract requirements, performance standards and service quality measures for the administration of crisis services. Any expansion of crisis team roles, including pre-screening of voluntary admissions, must be subordinated to the primary mission of crisis response services, namely short-term stabilization, linkage and referral, and appropriate follow-up/aftercare monitoring of all consumers.

Rationale: The current system has not focused sufficient resources on either effective short-term stabilization or follow up and monitoring of consumers post-intervention. This may result in a potential "revolving door" scenario for consumers. In addition, the crisis response system does not effectively address the needs of children/adolescents and family/caregivers.

Timely response to situations requiring mobile crisis intervention continues to be a matter of concern to consumers and family members in

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<sup>15</sup> For purposes of the TennCare Partners Program contract, the term "precertification" is equivalent to "prior authorization".

many areas. Consumers and family members/caregivers express concerns that an increasing volume of prescreening activity associated with voluntary admissions will stretch the finite resources of the crisis teams.

This recommendation is further addressed in Section D.

C. Assure that children and adolescents have access to crisis services provided by adequately trained personnel.

C-1 Each crisis team must have a designated specialist in child/adolescent mental health services on staff and must make arrangements for 24-hour availability of a child specialist for consultation. As a program goal over time, staffing should reflect the true demand for child/adolescent services or be proportional to the child/adolescent population served.

C-2 Ongoing cross training should be mandated for crisis teams to improve effectiveness of delivery of services to families and children. This training should involve personnel from other agencies responsible for providing services to children.

Rationale: The current crisis response system significantly under-serves children and adolescents in terms of overall utilization of crisis services. Crises present significantly differently for children and adolescents than for adults in terms of the preponderance of "psychosocial" versus psychiatric or clinical features. Therefore, it is important to assure that crisis response staff receives adequate training in interventions with children, adolescents and family members.

C-3 Provide a mechanism for ongoing monitoring focusing specifically on access and utilization of services by children and adolescents.

This recommendation is addressed in Section D.

- D. Develop a clear system of accountability by defining the roles of the Mental Health Planning Council-TennCare Roundtable, the BHO, local crisis program directors (or designees) and Bureau of TennCare administrative-staff in providing oversight and performance monitoring of crisis services.

Discussion: There is general agreement as to the variability in the quality of crisis services, the lack of specific accountability, and the lack of systematic monitoring of services in terms of access, performance standards, service quality and consumer outcomes.

The lines of responsibility for developing, implementing and monitoring system-wide standards for crisis and providing oversight of crisis services must be clearly defined for each of the following:

- Local crisis services provider
- BHO
- Bureau of TennCare Crisis Coordinator
- Mental Health Planning Council, TennCare Roundtable

#### Mental Health Planning Council, TennCare Roundtable Role and Responsibilities:

The Mental Health Planning Council, TennCare Roundtable should provide monitoring and continuing oversight of crisis services at a statewide level.

#### Bureau of TennCare Role and Responsibilities:

A designated lead Coordinator should be responsible for operational oversight and monitoring of crisis services. The TennCare Coordinator should be responsible for:

- Statewide monitoring of crisis services

- 
- Implementing statewide contract performance standards
  - Providing ongoing status reports to the TennCare Roundtable on identified issues and concerns.
  - Assisting in the development and implementation of best practice standards

#### BHO Role and Responsibilities:

Designate a BHO Crisis Services Coordinator responsible for:

- Monitoring of crisis services for compliance with performance standards, contract requirements, and service quality. Monitoring of service quality should include service audits, phone log review, consumer family member/ referral source satisfaction surveys as well as other methodologies.
- Implementation of standards for credentialing and training of crisis staff
- Liaison with local crisis service providers
- Liaison with the TennCare Crisis Services Coordinator to address system-wide problems or concerns that cannot be resolved on an individual program basis.
- Liaison with Mental Health Planning Council, TennCare Roundtable

#### Crisis Service Provider Role and Responsibilities:

Designate a Director of Crisis Services who will be accountable for:

- Developing policies and procedures as specified in Section III of this document titled "Policies and Procedures".
- Providing reports to the BHO Crisis Services Coordinator at least every six months on the adequacy of tracking, monitoring, linkage/referral, follow-up and outcome data on consumers.

E. The BHO in conjunction with TennCare should develop and implement a community outreach plan to effectively communicate Crisis Services Best Practices to consumers, family member/caregivers, and providers.



# **Attachment D**

## **Progress Report**

Section Number	Topic	Deadline	Progress
			percentage to the ratio obtained for the 416 report yields 21.9%. The percentage of overall screening compliance for Federal Fiscal Year 1997 is 24.6%
46	Baseline Percentage of Dental Screening Compliance		The baseline percentage of dental screening compliance for Federal Fiscal Year 1996 was 28.2%. There were 124,788 dental screens reported on the HCFA 416 for children in the age groups from 1-20. Since dental screens are not recommended until age 3, the total number of dental screens was divided by the total number of eligible member years of 3-20 years olds, which was 442,106. The resulting percentage was 28.2%. The dental screening percentage for Federal Fiscal Year 1997 is 31.1%
47	Screening Procedure and/or Diagnosis Codes		A letter was sent from TennCare on May 18, 1998, to the MCOs providing a list of screening procedure and/or diagnosis codes.
53	Review of Practices and Procedures for Referrals	120 days (7/11/98)	During the fall focus surveys the EQRO reviewed referral information from all MCOs. The EQRO found that all MCOs have mechanisms in place for referrals to specialists, behavioral health services, transportation services, and vision and dental care. The EQRO has developed recommendations specific to each MCO regarding modifications that they might make in their programs; these recommendations have been sent to the MCOs. The Quality Improvement Unit has received and reviewed all corrective action plans, from the MCOs. The Quality Improvement Staff will monitor the progress and implementation of the plans.
54	Provision of All Medically Necessary Services		The EQRO completed and submitted a report to the Bureau of TennCare in February 1999. All MCOs have submitted corrective action plans, and they have been reviewed and approved. The Quality Improvement Unit will monitor the progress and implementation of the plans.
55	Review of MCO Practices Re: Medical Necessity		Policies, procedures, and processes were reviewed by the EQRO during the 1998 fall focus review survey to assure that current utilization controls did not unreasonably deny or delay the initial or continued receipt of EPSDT medically necessary services. A

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*Treatment*

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Section Number	Topic	Deadline	Progress
	Decisions		report on this review was submitted by the EQRO to the Bureau of TennCare in February 1999. The report revealed that prior authorization of periodic or interperiodic screenings performed by primary care physicians for those under 21 was not required by any organization and five of the MCOs facilitated the referral process by allowing direct referrals to the next level of care by the primary care provider (PCP).
56	Definition of "Medical Necessity"		As part of its annual surveys of the MCOs, the EQRO reviewed provider manuals and member handbooks for contractual definition of "medical necessity". The "medically necessary" definition was noted in provider manuals, member handbooks and policies and procedures for six organizations. The remaining organizations have expressed their intent to publish the "medical necessity" definition in the manuals, handbooks and procedures manuals. The Quality Improvement unit will ensure that this occurs.  DCS incorporated the TennCare definition of "medical necessity" into its Provider Services Manual, which is an attachment to its provider contracts.
57	Absolute Limits; Utilization Controls		The EQRO collected some of this information as part of information collected for Paragraph 53 (above). The review of this information revealed that some limits on certain services were listed in member and provider handbooks for six organizations. Corrective action plans from the MCOs have been submitted to the Bureau of TennCare. All plans have been approved and will be monitored by the Quality Improvement Unit.
58	Standards and Procedures for Monitoring Utilization Review and Prior Approval Procedures	120 days (7/11/98)	The EQRO's 1998 focus survey of each of the MCOs revealed that only qualified people are making utilization review decisions.

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Section Number	Topic	Deadline	Progress
72	Notice of Rulemaking Re: Limits	30 days (4/11/98)	To date, medical record reviews have been completed for two inpatient psychiatric facilities.
73	Monitoring of Sample of DCS Children for Service Adequacy	120 days (7/11/98)	A rulemaking notice was submitted to the Secretary of State's Office at the end of March and filed in the April 15 Tennessee Administrative Register. The hearing was held on May 18. The rule became effective on September 27, 1998. DCS entered into a contract with the Vanderbilt Institute for Public Policy Studies to accomplish this project. Total contract amount: \$52,497.
74	Assurance of Non-Emergency Transportation		The EQRO has initiated the development of a tool, which was used during its focus surveys to examine the practices and procedures of transportation providers. Up until the time of the Consent Decree, the EQRO reviewed only the MCOs' oversight of their delegated transportation vendors. However, the EQRO began reviewing the transportation providers themselves as part of its annual focus reviews. Conclusions concerning appropriateness of subcontractor compliance were not possible to formulate due to lack of available information. All managed care and behavioral health organizations have submitted corrective action plans to address this area. All corrective action plans have been approved and are being monitored by the Quality Improvement Unit.
75	Prohibition of Blanket Restrictions on Transportation		BHO Contract Amendment 6 and MCO Contract Amendment 5 include a provision stating that transportation for children must include transportation for an accompanying adult but that transportation for a child shall not be denied due to lack of parental accompaniment. Both amendments have been finalized. The Contract and Compliance Unit recently requested copies of Transportation Policies and Procedures from all MCOs/BHOs. These policies are currently being reviewed.
77	Referral Protocols for		The EQRO prepared recommendations for the MCOs/BHOs. Each organization

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Section Number	Topic	Deadline	Progress
	Transportation		submitted corrective action plans to the Bureau. All plans have been approved and are being monitored for compliance by the Quality Improvement Staff.
79	List of Statewide Services	Within 180 days (9/11/98)	A list of statewide services was prepared and sent to the MCOs on September 22, 1998.
80	Coordination of EPSDT Services with Agencies on Statewide List	Within 240 days (11/11/98)	A TSOP has been prepared on this topic and is currently being reviewed at TennCare.
81	Process for Informing MCOs about Children with IEPs	Within 180 days (9/11/98)	A process was developed by TennCare and sent to the MCOs on September 11, 1998. All Special Education Coordinators in Local Education Agencies across the State were notified about sharing IEP information with PCPs. This notification occurred on September 11, 1998. A release form that schools could use in getting permission from parents to contact their children's MCOs was prepared and sent to the Special Education Coordinators on September 30, 1998. In addition, a TennCare handbook for Special Educators was prepared and distributed on December 1, 1998.
82	Strategies for EPSDT Coordination	Within 180 days (9/11/98)	A TSOP has been prepared on this topic.
83	Establishment of Commissioner's Task Force		The Commissioner's Task Force has been established. The staff committee is beginning the development of procedures for interdepartmental agreements and dispute resolution. Dr. Wadley has assumed this responsibility in connection with the TN KIDS Initiative.
88	Tennessee Commission on Children and Youth	120 days (7/11/98)	DCS has accomplished this activity.

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Section Number	Topic	Deadline	Progress
	Service Testing Process		
89-91	Creation of Expert Review Process	Contractor selected 45-- days; contract executed ---100 days	DCS entered into a contract with Paul DeMuro to perform this process. The report was submitted in September 1998. Total contract amount: \$97,931.25.
92	Remedial Plan	12/11/98	The State filed a proposed remedial plan with the Court on December 11, 1998. The Plaintiff's response identified perceived barriers to care and perceived design flaws in the defendant's plan. The defendants have continued to develop further proposals for delivering appropriate and effective health services to children in state custody with the goal of reaching mutual agreement on a remedial plan to be submitted for the Court's approval. The State filed an interim plan July 20 <sup>th</sup> 1999 and anticipates submitting a finalized revised proposed remedial plan to the Court shortly.
94	Tracking System	180 days (9/11/98)	The State already has a tracking system in the form of its systems for reporting encounter data.
95	DCS Tracking System	150 days (8/11/98)	DCS implemented its own EPSDT tracking system for children in DCS custody on July 1, 1998.
96	Monitoring and Reporting Compliance	120 days (7/11/98)	The TennCare Bureau Office has developed a reporting process.
97	Data on Provider Encounters		This system is in existence at TennCare.
98	Ongoing Audits of Encounter Data		The contract between the Bureau of TennCare and the managed care organizations (MCOs) specifies that "Individual encounter/claim data shall be reported in a

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			<p>standardized format as specified by TennCare and transmitted electronically to the TennCare agency on a basis specified by TennCare. The minimum data elements required to be provided are identified in Attachment II, Exhibit E of this Agreement.”</p> <p>#</p> <p>The Bureau of TennCare monitors submission of encounter data on an ongoing basis and takes action in the form of a withhold of 10% of the monthly capitation payment whenever it is determined that a contractor is not in compliance. Monthly retention of the withhold amount continues for each subsequent month so long as the identified deficiency has not been corrected. Any amounts withheld by TennCare for six consecutive months for the same compliance deficiency are retained permanently by TennCare. Information on the amounts withheld from each MCO/BHO due to encounter data reporting problems since the inception of the TennCare program is available upon request.</p> <p>TennCare staff have worked extensively with each MCO comparing summary statistics collected and self-reported by the MCO from claims data with summary statistics generated by TennCare from encounter data submitted by the MCO. Much time and effort has been spent identifying the reasons for any discrepancies between these two data sources and implementing corrective action to assure the accuracy of encounter data. We are now very satisfied that the TennCare MCO encounter database is complete and accurate, and we are beginning to generate MCO specific information concerning service delivery. The process described above is ongoing for the BHOs.</p> <p>Several reports have been issued presenting MCO specific service delivery information. The “MCO Preventive Services and Ambulatory Care Report ” allows for an MCO by MCO comparison of well child screening rates, child dental visit rates, pap smear and</p>

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			<p>mammography screening rates and rates of hospitalization for ambulatory care sensitive conditions. Other encounter data-based reports have analyzed emergency room utilization, prevalence and treatment of ADHD, pediatric asthma ER visits and hospitalization rates, and hospitalization rates among diabetics. Each of these reports has provided MCO and region specific information. These reports serve an important data validation function. MCOs are required to submit corrective action plans if their performance in a particular area is unacceptable. In order to develop an appropriate corrective action plan, the MCO must first determine whether the apparent poor performance is due to a data reporting problem or a true service delivery problem. The Bureau then monitors the implementation of the corrective action plan and progress can be tracked through annual repetition of the encounter data-based studies.</p> <p>Encounter data validation is a high priority and ongoing activity within the TennCare Bureau. Another data validation activity involved an extremely large perinatal study in which approximately 25,000 TennCare births were identified from a linked TennCare enrollment - birth certificate file. Encounter data was then analyzed to determine if the birth had been reported to the TennCare Bureau. Overall, approximately 95% of births were accurately reported through the encounter data system.</p> <p>In addition to the activities described above, TennCare builds a data validation component into any medical record review, which is conducted to assess a quality of care issue. Given our commitment to ongoing quality of care studies, we envision that our future activities in the area of data validation will continue to be linked with these endeavors. As a result, staff intensive activities such as linking existing data systems and medical record review can serve multiple quality assurance functions.</p>

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			Currently, there are withholds in place for two managed care organizations for failure to submit monthly encounter data.
99	Selection of Contractor to Conduct Services Testing on a Sample of Plaintiff Class Members	Select contractor within 60 days; execute contract within 120 days	TennCare has selected two contractors to carry out this project. East Tennessee State University (ETSU) has been chosen to conduct an analysis of a random sample of the entire TennCare population of children and adolescents. The Total amount of the ETSU contract is \$454,650, which includes in-kind contributions from ETSU. A request to extend the contract until the fall has been approved and awaiting final signatures from both parties. The majority of medical records have been received and ETSU is in the process of abstracting these records and entering information into their computer files.
			The University of Tennessee at Memphis is conducting an analysis of a cohort of 400 children who have been labeled Seriously Emotionally Disturbed, as well as 400 Severely and/or Persistently Mentally Ill adults. The total amount of the UT-Memphis contract for a three year period is \$1,301,618, which includes in-kind contributions from UT-Memphis. There have been a number of unforeseen delays in getting the UT-Memphis project underway during the past six months, and NAMI (the National Alliance for the Mentally Ill) withdrew from the project in June. The Bureau of TennCare is currently assessing whether the information that was being sought from the project can be obtained in other ways.
100	Policy Clarifications and Guidelines		These are being developed as needed. TSOP 036 and Addendum 1 was published in April of 1999. The TSOPs provide policy clarification on the EPSDT mandate and outreach and informing requirements.
101	Review of Appeals	Every six	The Appeals Unit is responsible for identifying those appeals where there appear to be

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Section Number	Topic	Deadline	Progress
		months, beginning on 7/1/98	EPSDT violations and forwarding information on them to TennCare for assessment of liquidated damages as appropriate. The overall report on appeals for the period from January-June 1999 revealed that there were 460 appeals recorded by the Appeals Unit. The care types with the highest number of appeals were residential treatment (75), durable medical equipment (55), pharmacy (47), and dental (45).
102-103	Review of Provider Contracts	60 days (5/11/98)	The Tennessee Department of Commerce and Insurance (TDIC) has completed its review of MCO and BHO contracts, as well as DCS contracts. The Contract Development and Compliance Unit at TennCare analyzed TDCF's review and prepared feedback for the MCOs, BHOs, and DCS. A total of 265 contracts were reviewed. Of this total, 162, or 61%, were found to contain language that might potentially encourage violations of the EPSDT mandate. Each MCO and BHO was notified in writing of the findings of the review and was given until September 25, 1998, to formulate a detailed corrective action plan for revising the deficient contracts. Nine of the 11 contractors completed the required corrective action plan within the specified time period. The two remaining contractors submitted either late or insufficient reports, and appropriate penalty actions have been taken to insure their subsequent compliance. All new or revised provider agreements will be monitored by the Office of Contract Development and Compliance to assure that they contain no components, which would discourage compliance with EPSDT.
104	Semiannual Reports	7/31 and 1/31 of each year	The State filed the first Semiannual Report on July 31, 1998. A second report was filed at the end of January 1999 and the third report will be filed at the end of July 1999.
106	Quarterly Meetings with Plaintiffs' Attorneys		To date, meetings have been occurring more frequently than quarterly.
107	Attorneys' Fees	60 days	Plaintiffs' attorneys' fees of \$98,663 were authorized for payment by the Attorney

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<b>Section Number</b>	<b>Topic</b>	<b>Deadline</b>	<b>Progress</b>
		(5/11/98)	General's Office as of August 25. Of this amount, \$92,152 was paid to the Tennessee Justice Center, \$4,635 was paid to the National Health Law Program, and \$1,876 was paid to the Bazelon Center for Mental Health.
113	Notification of Class Members		After review by the plaintiffs' attorneys, a MCO newsletter notice was sent to all MCOs on April 13, 1998. After review by the plaintiffs' attorneys, a description of the settlement was sent to the hotlines and the MCOs on May 11, 1998.
114	Notification of Persons with Disabilities		TennCare has sent letters containing the description of the settlement mentioned above to well over 200 advocacy organizations for distribution to their members and constituents. The description has also been circulated to providers in the State's Immunization Program.
115	Attachment of Information in Newly Approved TennCare Eligibles' Notice of Eligibility		An announcement has been prepared regarding the availability of EPSDT services. The announcement was added to the "new member" letters sent out by TennCare. This on going project was implemented July 8, 1999.

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**Attachment E**


**Behavioral and  
Developmental  
Screening Guidelines**

# **Attachment F**

## **Revised Proposed Remedial Plan**

outside the MCO/BHO structure, to deliver comprehensive EPSDT periodic screenings for DCS custody children. These same providers will serve as their “medical homes.” Children who need diagnostic or treatment services that are more specialized than those which can be provided by the primary care provider will be referred to the MCOs and BHOs for specialty service. The State will identify the types of behavioral health providers who must be available to treat complex mental health needs of children in State custody, and the BHOs will be required to establish adequate networks of those specialized providers. Failure of MCOs and BHOs to respond to referrals for necessary specialty services (whether medical or behavioral) in a timely and appropriate manner will result in the direct purchase of those services by the State. A “reverse medical necessity” process will be utilized in referrals for specialty services. MCO/BHO disputes over the existence of medical necessity for covered services as to which there has been a referral will be resolved between the MCO/BHO and the TennCare Bureau after the service has been delivered to the child.

Until such time as these and other initiatives can be implemented, the defendants will undertake the following interim measures.

 DCS has implemented the recommendation of the DeMuro Report that they establish Health Units in each DCS region.<sup>2</sup> The staff of the new units will play an important role in insuring that TennCare services for DCS custody children are delivered as they are supposed to be. They will be

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<sup>2</sup>DCS has implemented a Health Unit in each of its 12 regions whose goal is to provide programmatic supports in the areas of behavioral and medical services for children in state custody. They are assisting in the access of services or needed referrals for services for DCS children, and are a resource for case managers on behavioral or medical concerns for the children in their case load. Health Units are comprised of a DCS TennCare representative, a Nurse Practitioner or other nurse appropriately licensed and educated, and a part time clinical psychologist or licensed clinical social worker.

available to assist DCS staff who are attempting to get services for custody children. They will also be instrumental in communicating with medical professionals in the MCOs and BHOs to explain more clearly what the children's health care needs are. These Health Units, working with TennCare and the DCS case managers, will identify any failures of the MCOs/BHOs to offer appointments within the time limits required by their contracts with the State and will report this information to TennCare so that TennCare can take appropriate action against the MCOs/BHOs.

2. In cases where covered services prescribed by a qualified provider<sup>3</sup> for a State custody child are denied by an MCO or BHO, DCS will notify the TennCare Chief Medical Officer. The TennCare Chief Medical Officer will contact the MCO/BHO Medical Director in an effort to resolve the issue. If the MCO/BHO Medical Director and the TennCare Chief Medical Officer are unable to reach consensus on a health or mental health service to be delivered to a State custody child and the TennCare Chief Medical Officer believes that the child's needs are such that delivery of the service cannot be postponed until the appeals process is completed, the State will purchase the service directly for the child. The TennCare Chief Medical Officer will authorize payment for direct services only in

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<sup>3</sup>A "qualified provider" is a network provider or a provider to whom a referral has been made by an MCO, BHO, or PCP.

those situations where a crisis exists, where the MCO/BHO has been notified of the request and has been unwilling or unable to provide the service, and where the delivery of the needed service cannot wait for the normal or expedited appeals procedure to be completed.

Other interim measures include the following:

1. DCS liaisons at the MCOs and BHOs

Each MCO and BHO will identify designated DCS liaison personnel at their offices who will be available to provide direct assistance to DCS case managers if there are difficulties in scheduling needed appointments for custody children.

2. EPSDT screens and interperiodic screens

DCS case managers are responsible for scheduling needed EPSDT screens, as identified in the TennCare periodicity schedule, and interperiodic screens for children coming into custody. (DCS case managers may delegate this responsibility to foster parents where appropriate but only when the foster parent's responsibility has been clearly communicated to him/her by the DCS case manager.) EPSDT screening and interperiodic screenings with the MCO will occur within 3 weeks of request. EPSDT interperiodic screenings with the BHO will occur within 14 days of request. DCS liaison personnel at the MCOs and BHOs will be available to assist the DCS case managers if there are any problems either in identifying a provider or scheduling an appointment. DCS case managers and/or foster parents will be responsible

for assuring that appointments are kept by DCS children. The DCS case manager shall document any failures on the part of the MCOs/BHOs to meet their obligations as stated above and shall report these failures to the DCS Health Unit, which shall report them to TennCare so that TennCare can take appropriate action.

3. Timeframes for care

DCS case managers will be responsible for scheduling appointments for needed care for DCS custody children. (DCS case managers may delegate this responsibility to foster parents where appropriate but only when the foster parent's responsibility has been clearly communicated to him/her by the DCS case manager.) The DCS case manager will work with the DCS Health Units and the MCO/BHO liaisons if there are problems in scheduling appointments. It is the responsibility of the DCS case manager to be sure that the scheduled appointment is kept by the child. The DCS case manager shall document any failure on the part of the MCOs/BHOs to meet their obligations as stated below and shall report these failures to the DCS Health Unit, which shall report them to TennCare so that TennCare can take appropriate action.

Covered services must be delivered by the MCOs/BHOs within the following contractual  
timeframes:

- a. The MCO is required to deliver routine primary care services,

general dental care, general optometry care, and lab and X-ray services within the "usual and customary" community standard, not to exceed 3 weeks. All other services must meet the usual and customary standard for the community. ("Usual and customary" is defined as access that is equal to or greater than currently existing practice in the fee-for-service system.) The MCO is required to assure that appointments for specialty care shall not exceed 30 days for routine care and 48 hours for urgent care. All emergency care is immediate, at the nearest facility available, regardless of contracts.

- b. The BHO is required to deliver outpatient mental health services within 14 calendar days for non-emergency services; within 4 hours for an active client in an urgent situation (1 hour if medication related); and within 3 working days for all other urgent situations. All emergency care is immediate, at the nearest facility available, regardless of contracts.

4. Special procedure for mental health services

The following special procedure will be implemented for BHO-covered mental health services:

- a. If the BHO does not provide the EPSDT interperiodic screen within the timeframes set out in the TennCare/BHO contract, the DCS Health Unit will notify TennCare so that TennCare

may begin the process of levying liquidated damages against the BHO in accordance with Section 5.3.3.3 of the TennCare/BHO contract.

- b. If, after conducting the EPSDT interperiodic screen, the BHO provider does not believe that there is a medical necessity for further mental health services for the child, then the DCS case manager shall document this finding. If the DCS case manager or the DCS foster parent disagrees with the BHO provider, the DCS case manager will contact the psychologist in the DCS Regional Health Unit. If, after examining the child's records, the DCS psychologist believes that further mental health services are needed for the child, then the DCS psychologist will contact the BHO and make a referral for the services. The BHOs will treat referrals from DCS psychologists just as they would referrals from in-network BHO providers.<sup>4</sup> It is expected that the DCS psychologist will confer with the BHO prior to making a referral for a service for a particular child. The BHO will have the discretion to determine that the referral is not medically necessary, but the BHO can do so only with provision of appropriate notice and all appeal rights.

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<sup>4</sup>TennCare will formalize this process in an appropriate contract amendment.

- c. If the BHO does not deliver the requested mental health services or provide a denial of the service with appropriate notice and appeal rights within the required timeframes, the DCS Health Unit will document the BHO's failure and report it to TennCare so that TennCare can begin taking action to levy liquidated damages against the BHO, in accordance with Section 5.3.3.3 of the TennCare/BHO contract.

It is the defendants' expectation that the revised remedial plan now being developed will render moot or inapposite most, if not all, of the plaintiffs' criticisms of the original proposal. Nevertheless, there are a number of basic and pervasive flaws underlying plaintiffs' response, which warrant at least brief discussion at this point.

First, in criticizing the initiatives set out in the defendants' plan to address systemic issues in the delivery of EPSDT services to children in the custody of the Department of Children's Services (DCS), the plaintiffs have ignored the provisions of the Consent Decree entered on March 11, 1998. The Consent Decree contains a comprehensive set of measures designed to function as a cohesive whole to achieve full compliance with EPSDT requirements within a five year timeframe. A remedial plan focused on DCS custody children must be read as supplemental to that Consent Decree, and proposed initiatives must be evaluated as operating in conjunction with the remedial provisions already agreed upon by the parties and approved by the Court as appropriate measures that will enable TennCare to achieve and maintain compliance with its EPSDT obligations.

Second, plaintiffs' response is driven by a fundamental dissatisfaction with the state's

utilization of a managed care structure for the provision of services to DCS custody children. Plaintiffs' underlying policy agenda is captured succinctly in one phrase: "If the state insists upon continuing to utilize the MCOs and BHOs . . . ." (Plaintiffs' Response, p. 23). Using that perceived core structural defect as a touchstone for evaluation of the defendants' proposed remedial plan, plaintiffs have pronounced it deficient. But the Consent Decree itself recognizes and countenances the fact that EPSDT services are, and will continue to be, provided in the context of a capitated managed care service delivery model. And, to the extent that plaintiffs' criticisms of the state's proposed remedial plan suggest that they will urge the Court to reject any proposal that does not effect a fundamental restructuring of the managed care model for services for children in DCS custody, plaintiffs' response reflects a third pervasive flaw. It fails to recognize that principles of federalism and separation of powers impose limitations on the exercise of the equitable powers of the federal court, limitations that are inconsistent with the judiciary assuming responsibility for making fundamental policy judgments that state officials "are both constitutionally entitled and uniquely qualified to make." *Lewis v. Casey*, \_\_\_\_\_ U.S. \_\_\_\_\_, 116 S.Ct. 2174, 2197, 135 L.Ed 2d 606 (1996) (Thomas, J., concurring).

Finally, while the Consent Decree contemplated a process of contracting with a consultant to identify and make recommendations regarding problems with the systems that affect the delivery of health care for children in DCS custody (§ 35), it was expressly acknowledged, with respect to the development of policies and procedures to ensure appropriate care for those children, that the "authority for initiating and developing policy belongs to the state." (§ 33). While the plaintiffs are to be afforded a means of "evaluating and influencing state policies as they are developed," the agreed-upon remedial process "recognizes the primacy of the state's authority and responsibility."

(¶ 35). The Consent Decree's recognition of this fundamental principle is simply a reflection of the fact that, "under the Constitution, the first question to be answered is not whose plan is best, but in what branch of the government is lodged the authority to initially devise the plan . . . . The wide range of 'judgment calls' that meet constitutional and statutory requirements are confided to officials outside of the judicial branch of government." *United States v. Michigan*, 940 F.2d 143, 159 (6th Cir.1991).

The state has not relinquished to either consultants or plaintiffs' counsel its discretionary authority over its own programmatic and budgetary operations. And, while it has been recognized that judges, no less than others, may have "a natural tendency to believe that their individual solutions" to complex systemic problems "are better and more workable than those of the persons who are actually charged with" the running of the program under examination, judges' "unique and limited role . . . does not allow them to substitute their views for those [of state officials] who have the constitutional authority and institutional expertise to make these uniquely nonjudicial decisions and who are ultimately accountable for these decisions." *Bell v. Wolfish*, 441 U.S. 520, 562, 99 S.Ct. 1861, 1886, 60 L.Ed. 2d 447 (1979); *Lewis v. Casey*, 116 S.Ct. at 2198.

It is even less appropriate for plaintiffs' counsel -- who are free from any accountability for the consequences -- to either fashion or insist upon, over the state's objection, "remedial" measures that will dictate fundamental policy and structure in the operation of a core state program. As the Consent Decree itself recognized, plaintiffs and their attorneys "lack the information or resources to effectively evaluate policies much less develop them on their own." (¶ 33).<sup>≡</sup> In many respects, plaintiffs' response to the defendants' proposed remedial plan illustrates the accuracy of that concession. It is perhaps most graphically evident in the plaintiffs' self-devised procedures for

“immediate relief.” (Plaintiffs’ Response, pp. 37-40).

Plaintiffs submit that children in the State’s custody simply cannot wait until the reforms called for in the Consent Decree and defendants’ proposed remedial plan are achieved and, therefore, immediate provision for addressing their most urgent needs must be made. Plaintiffs assert that under the current procedures, the “default mode” is denial of care and that their self-devised plan of immediate relief will somehow address this problem. To that extent, plaintiffs’ counsel has proposed a system whereby foster parents and/or DCS case workers are given virtually complete authority to determine how the medical and mental health needs of children in custody are to be met, with unfettered discretion in exercising that authority.

This plan as described, however, virtually guarantees that the MCOs and BHOs will not be able to comply with the terms and conditions of that process, thereby essentially by-passing the fundamental component of TennCare --managed care. Additionally, plaintiffs’ self-devised plan of immediate relief is counter-productive to measures currently being implemented by the defendants pursuant to the Consent Decree , as well as further development and implementation of defendants’ revised proposed remedial plan. Furthermore, there are a number of aspects of plaintiffs’ proposed “immediate relief” that simply cannot be implemented, in particular the requirement that DCS must maintain the capability of making electronic funds transfers.

Finally, contrary to any beliefs held by plaintiffs’ counsel, such a plan could not be implemented immediately and would require the defendants to divert substantial resources and manpower away from the implementation of procedures currently ongoing pursuant to the terms of the Consent Decree and from further development and implementation of defendants’ revised proposed remedial plan. Conversely, the State’s proposed interim measures could be implemented

immediately without such diversion of State resources.

#### A. Elements Of Plaintiffs' Proposed Plan Of Immediate Relief

1. *All foster parents and DCS case workers with direct responsibility for individual children should be immediately trained and given appropriate written instructions informing them of the children's EPSDT rights and the procedures for implementing those rights.*

The first element of plaintiffs' plan of "immediate relief" calls for immediate training of all foster parents and DCS case workers as to children's EPSDT rights and the procedures for implementing those rights. Presumably, the "procedures" plaintiffs refer to are the self-devised procedures outlined in plaintiffs' plan of immediate relief. As already discussed, these procedures are radically different from current procedures and/or the procedures currently being developed and to be proposed in the defendants' revised proposed remedial plan. Further, they represent a fundamental change in policy for the State. Accordingly, before any such training could take place, DCS would have to have the necessary time to establish internally the procedures outlined in plaintiffs' plan. How long such implementation would take is unknown, as it would require coordination with other state departments or agencies; contract amendments with the various MCOs and BHOs; and HCFA approval, among other things --all of which are discussed in further detail herein.

Once such internal procedures are established --assuming that it is even possible to establish the procedures proposed by plaintiffs' counsel --it would then be necessary to develop a curriculum on these procedures. It is estimated that it would take at least a month to collect the necessary

material and to develop an appropriate and adequate curriculum.

Only after the procedures have been established internally and the appropriate curriculum developed could this "immediate training" of foster parents and DCS case workers then take place. Plaintiffs' proposed plan requires that all foster parents and DCS case workers "with direct responsibility for individual children" receive training. (Plaintiffs' Response at p. 38). In accordance with this requirement, it is estimated that there are 2900 foster parents and 1150 DCS case workers who would need to be trained. Thus, even assuming that DCS engaged in full-time training, it would take a *minimum* of three months to train all the foster parents and DCS workers.

Thus, at the very least it would take a minimum of four months to implement this first element of plaintiffs' proposed plan of "immediate relief," which is the easiest element of plaintiff's plan to implement. Moreover, in order to achieve full implementation in such a time frame, DCS would be required to focus substantial resources solely to this task, and other activity within the sphere of TennCare, including activity currently taking place pursuant to the Consent Decree and the defendants' further development and implementation of its revised proposed remedial plan, would be detrimentally affected. Indeed, DCS has already developed a curriculum and begun implementation of the training of DCS case managers in accordance with the terms of the defendants' previously submitted Proposed Remedial Plan. This curriculum includes, among other things, training on managed care; prior authorization; the role of the primary care physician; covered services, including EPSDT screening services; and how to access both medical and behavioral services for children in custody. To now require DCS to establish an entirely new procedure --plaintiffs' self-devised plan of "immediate relief" --and then train foster parents and DCS case managers on that procedure, a process estimated to require at least four months, would clearly be

counter-productive to the initiatives that the defendants have already undertaken, as well as the additional initiatives that the defendants have been developing, with the input of plaintiff's counsel.

2. *DCS should be required to immediately designate management staff positions with the authority to authorize expenditure of funds in accordance with the procedures outlined below. Such staff must be available to foster parents and DCS case workers on a 24-hour a day, 7-day a week basis, in order to be able to meet the children's needs for urgent care.*

This next element demonstrates one of the more impractical aspects of plaintiffs' proposed plan. It requires DCS to immediately designate "management staff positions," who must have the authority to expend funds and be available on a 24 hour/7 day a week basis "in order to be able to meet the children's needs for urgent care." Yet, under the process plaintiffs' counsel have proposed, the only function that these DCS "management staff positions" will serve is to "immediately make arrangements to ensure payment for the child's care." (Plaintiffs' Response at 39). There simply is no reason why such payment could and should not be transacted during regular business hours. As such, there is absolutely no need to have designated DCS staff available around the clock solely for the purpose of making arrangements for the payment of a child's care.

Obviously, this element of plaintiffs' proposed plan of immediate relief also cannot be implemented immediately, as it would first require identification of those DCS employees capable of being designated "management staff" and a determination if there are sufficient numbers to meet the requirement of 24 hour/7day availability. Additionally, if the sole function of these designated "DCS management staff" is to authorize and make arrangements for the payment of a child's care, clearly it will be necessary for DCS to develop the necessary internal procedures and policies to implement this authorization and payment of funds. These will clearly take some time to develop.

Moreover, to the extent that they would include authorization for expenditure of TennCare funds, such procedures and policies would have to be approved by the Bureau of TennCare and/or the Department of Finance and Administration. It is uncertain, at this time, whether HCFA approval would also be required.

In any event this element cannot be immediately implemented. Furthermore, the State cannot, nor should it be required to, simply designate certain DCS employees as "management staff" and then hand those individuals a checkbook, as plaintiffs have essentially proposed in the plan for immediate relief.

3. *When a foster parent or DCS case worker obtains a prescription for medical or mental health care for a child in custody, the foster parent or case worker must immediately inform the appropriate DCS liaison, and the child's TennCare MCO or BHO, either phone or by fax. Brief information, as specified in forms to be promulgated and distributed by DCS, should be provided with these reports.*

This element has a number of problems. In the first instance, it cannot be implemented immediately. It specifically calls for the development of forms by DCS that it will then distribute presumably to all DCS case workers and foster parents. These forms would clearly need to be developed in conjunction with the MCOs and BHOs, in order to ensure that they are uniform; that all relevant information is requested; and that such information is in the proper format. It is estimated that it would take at least two weeks to develop these forms, and several more weeks to distribute them to all of the approximately 2900 foster parents and 1150 DCS case workers.

However, mere distribution of these forms to case workers and foster parents will be ineffective unless training on how to utilize these forms is also provided. Thus, it will be necessary

for the case workers and foster parents to be trained not only on the use of this form, but also on the additional responsibility that plaintiffs' plan will place on them --the responsibility of immediately contacting the child's MCO/BHO with the requisite information whenever a prescription for a child's medical or mental health care is obtained.

Whether such training could be included in the training called for in the first element of plaintiffs' plan is uncertain, because it would require the development of these forms and a curriculum for training on the use of these forms simultaneously with the development of a curriculum, as discussed in the first section. Obviously, this multiple development track would require even further resources to be diverted away from other TennCare initiatives currently being developed and implemented by the defendants. Furthermore, given the specificity of the training that would be needed on the use of these forms, it is most likely that separate training would be required, which would, of course, further extend the timetable for implementation of plaintiffs' allegedly "immediate" plan of relief.

4. *The TennCare MCO or, as appropriate, BHO, should have 24 hours from the submission of the report within which to schedule an appointment for the prescribed treatment and arrange needed transportation. To meet this requirement, the appointment must be timely, in light of the urgency of the child's health or mental health needs. (For purposes of determining the timeliness of scheduling, the TennCare risk agreement with the MCOs/BHOs and the terms and conditions of the waiver will be the standard).*

This element of plaintiffs' proposed plan for immediate relief readily demonstrates plaintiffs' total aversion to managed care, and contains a number of erroneous assumptions. First, plaintiffs erroneously assume that every prescription received by a caseworker or foster parent is for a

medically necessary service or treatment. Under the plan, the MCOs and BHOs are given only 24 hours within which to make an appointment once they receive a prescription (either by telephone or fax) from a DCS caseworker or foster parent, with no discretion whatsoever to make a determination as to whether the service or treatment prescribed is medically necessary. Indeed, "medically necessary" is simply not an element of Plaintiffs' plan, but has been completely eliminated. Thus, under plaintiffs' plan, the only function served by the MCOs and BHOs is to make appointments --and even then, in only a very limited time period.

Second, plaintiffs' erroneously assume that appointments for medical services and/or treatment (on a non-emergency basis) can be made any day of the week and within 24 hours. Most, if not all, medical providers are available to schedule appointments during regular business hours Monday -Friday. Thus, if a MCO or BHO receives a prescription from a caseworker or foster parent on Friday, it has only a few hours to try and schedule the appointment and not 24 hours. Moreover, plaintiffs erroneously assume that all the foster parents and caseworkers will immediately notify the MCOs/BHOs upon receipt of a prescription and provide all the necessary information on the requisite form. The reality is, however, that not all caseworkers and foster parents will act so conscientiously. Thus, if the caseworker or foster parent does not provide all the necessary information and/or act timely, the MCO/BHO is substantially hindered in its ability to fulfill its obligations under plaintiffs' proposal. In addition, even if the caseworker or foster parent is unintentionally delayed in notifying the MCO/BHO, if the MCO/BHO does not receive the prescription until the weekend, it simply cannot meet the 24-hour deadline for making appointments.

Clearly, with this element, plaintiffs have only paid "lip-service" to the notion of managed care and have structured their plan such that it will not succeed. Moreover, to implement this

element of plaintiffs' plan would require another amendment to the contracts with the MCOs and BHOs. It is highly unlikely that these entities would agree to amend their contracts: (1) to eliminate their ability to exercise discretion in determining what services and treatments are "medically necessary"; and (2) to agree to schedule appointments and arrange needed transportation within 24 hours of receipt of a prescription from a foster parent or DCS caseworker. In any event, it is estimated that it would take at least six months to try and negotiate such contract amendments with each of the MCOs/BHOs.

5. *If the foster parent or DCS case worker has information that the child is exhibiting symptoms and requires an EPSDT interperiodic screening (as defined in paragraph 42 of the Consent Decree), the foster parent or case worker should be required to report that fact to DCS and MCO or BHO in the same manner. The MCO or BHO should be given 24 hours within which to schedule a timely appointment for such an inter-periodic screen.*

The problems with this element of plaintiffs' proposed plan of immediate relief are the same as those discussed above with respect to # 3 and 4. This element would require, in addition to the training of the case workers and foster parents and creation of appropriate forms, amendments to the contracts with the MCOs and BHOs to allow for direct referrals from non-licensed, non-medical professionals, i.e., the foster parents and caseworkers. None of these elements of plaintiffs' plan, even if possible, can be implemented immediately, and would take at a minimum six months to implement.

6. *If the MCO or BHO fails to schedule appropriate screening or treatment of the child within 24 hours of receipt of a request as outlined here, the foster parent or case worker must notify the DCS management representative. The*

*DCS management representative must immediately make arrangements to ensure payment for the child's care on such terms as the foster parent or case worker can promptly arrange on the local market. For these purposes, DCS must maintain the capability of making electronic funds transfers or wiring money with sufficient promptness to ensure the child's timely receipt of care.*

This element of plaintiffs' proposed plan best demonstrates how unrealistic the proposal is. Plaintiffs simply assume that not only could DCS establish a procedure for making electronic funds transfers and/or wire transfers, but that it could establish such procedure immediately. Electronic funds transfers require detailed prior arrangements, including bank account numbers, transit numbers and authorization, as well as W-9 forms being completed. Wiring of funds is a manual process that requires equipment linked to the Federal Reserve System. The current infrastructure of state government requires that any electronic fund transfers or wiring transactions first be approved by the Department of Finance and Administration and then sent to the Department of the Treasury for the actual transaction, as the monies reside in the State Treasury. Thus, any process established by DCS would necessarily require the participation and approval of the Department of Finance and Administration and the Department of Treasury.

Furthermore, in order for electronic funds transfers or wiring of funds to occur in the manner outlined in plaintiffs' proposed plan, the State would need to pre-arrange such transactions with every potential provider in the state. Whether these potential providers would even be willing to agree to such an arrangement is uncertain, particularly since these providers would have to provide their bank account numbers and other similar financial information to the State, all of which would presumably then be public records and open to public inspection. Additionally, procedures would have to be developed to address new providers, providers with licensure problems, and/or providers

retiring or leaving the state. Clearly, the development of such procedures, along with implementation of agreements with all potential providers in the state --even assuming that such agreements could be implemented --would take a considerable amount of time and, therefore, would do nothing to address the issue of immediacy stressed in plaintiffs' proposal.

Additionally, to the extent that plaintiffs' proposal implies that payment in this manner needs to be made before services are rendered, such implication is entirely unrealistic. First, it should be noted that the automatic clearinghouse (ACH) for electronic funds transfers do not process for three days. Furthermore, the State simply cannot be expected to provide reimbursement for services not yet rendered, particularly when those services have been "locally bartered" by the foster parent or DCS caseworker. The potential for fraud and abuse in such a situation is enormous and would expose the State to tremendous unforeseen liability, as well as losses resulting from simple human errors (e.g., transpositions or typographical errors).

Finally, because this procedure would involve the use of TennCare monies, including federal funds, outside the managed care process, implementation of such a process would potentially require HCFA approval.

In conclusion, plaintiffs' proposed plan for immediate relief contains two fundamental flaws: (1) it places all the authority and discretion to determine the medical and mental health care needs of children in custody in the hands of non-medical professionals, i.e., foster parents and DCS case workers; and, (2) it cannot, both physically and realistically, be implemented immediately and, therefore, does nothing to address the urgent needs of children asserted by plaintiffs' counsel. Additionally, implementation of plaintiffs' proposed plan would require a substantial diversion of DCS and TennCare's resources away from implementation of the initiatives called for in the Consent

Decree, and the further development and implementation of defendants' revised proposed remedial plan.

Conversely, the State Defendants have proposed interim measures that are calculated to be quick and effective in addressing those urgent needs during the period that the initiatives and procedures in defendants' revised proposed remedial plan are fully developed and implemented.

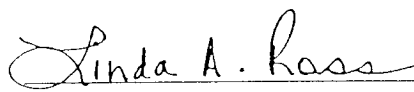
### CONCLUSION

The Plaintiffs' proposal for "immediate relief" should be denied, as should their request that the defendants be required to submit to a process of obtaining outside consultants' approval and "certification" of the State's remedial plan.

Defendants request that this Court grant the defendants' motion for extension of time to file their revised proposed remedial plan, which motion has been submitted contemporaneously with this Reply.

Respectfully submitted,

PAUL G. SUMMERS  
Attorney General and Reporter

  
LINDA A. ROSS  
Special Deputy Attorney General  
B.P.R. No. 4161

*Janet M. Kleinfelter*

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(615) 741-1771

### CERTIFICATE OF SERVICE

I hereby certify that a true and exact copy of the foregoing document has been sent by U.S. Mail, first class, to Gordon Bonnyman and Michele Johnson, Tennessee Justice Center, 916 Stahlman Building, 211 Union Street, Nashville, Tennessee 37201 on this the 20<sup>th</sup> day of July, 1999.

*Linda A. Ross*

LINDA A. ROSS

# **Attachment G**

## **DCS Complaint Form**



STATE OF TENNESSEE  
BUREAU OF TENNCARE  
DEPARTMENT OF HEALTH  
729 CHURCH STREET  
NASHVILLE, TENNESSEE 37247-6501

**TO:** Mary Beth Franklyn, Attorney  
Department of Children's Services

**FROM:** Kasi Tiller  
Bureau of TennCare

**DATE:** February 10, 1999

**SUBJECT:** DCS Complaint Process

The special complaint process for Department of Children's Services (DCS) case managers and TennCare representatives to utilize to identify and report problems related to accessing services through the MCOs and BHOs is ready for implementation, effective February 16, 1999.

The process incorporates the use of a complaint form, which will include problem-solving strategies. The attached form can be completed by the DCS case manager or the regional TennCare representative and mailed or faxed to the TennCare Complaints Coordinator.

Initially, the DCS case manager experiencing difficulty in accessing services for children in custody, should complete the form to indicate that the necessary steps have been taken in an effort to resolve the problem(s). This endeavor will be enhanced through training for DCS case managers on access and advocacy of TennCare services. DCS case managers are also encouraged to utilize their TennCare representative in problem solving strategies. However, if the TennCare representative is unavailable or unable to assist the case manager in a timely fashion, the DCS case manager should mail or fax the completed form to the TennCare Complaints Coordinator. Any forms received that are not completed or lack initial problem solving strategies will be returned to the case manager or to the TennCare representative for completion.

TennCare enrollees have the right to appeal any action taken by the MCO/BHO to deny, reduce, terminate, delay or suspend a covered service that is ordered or prescribed by a participating provider. This complaint process for DCS case managers and TennCare

representatives does not replace the appeals process, but rather provides another vehicle for communicating information about systemic issues and problems. TennCare wants to know if there are actions that need to be taken to ensure that the MCOs and BHOs provide all covered services as required in their contract with the State.

TennCare complaints from DCS case managers and TennCare representatives will be logged, monitored and given top priority for follow-up action by TennCare staff, generally within one business day. Complaints will be analyzed regularly to determine if there are systemic issues and problems that need to be addressed by the Bureau of TennCare or DCS.

Should you need assistance with training or have questions, concerns, suggestions or comments regarding this process, please don't hesitate to call me at (615) 532-6089. This process can be massaged, as necessary, to ensure that the form for reporting problems to TennCare is a user-friendly tool that identifies potential, systemic issues and problems that need to be addressed.

CC: Brian Lapps  
Susie Baird  
Barbara Evans  
Sarah Barr  
Annette Grossberg  
Dr. Judy Regan  
Mary Jo Price

# DCS Form for Reporting Problems to TennCare

**Instructions to DCS worker:** Are you having a problem with TennCare for a particular child with whom you are working? Please check any boxes on this form that apply, and send the form to:

Complaints Coordinator  
Division of Quality Improvement, Bureau of TennCare  
729 Church Street  
Nashville, Tennessee 37247-6501

or fax the form to:

Complaints Coordinator  
Division of Quality Improvement, Bureau of TennCare  
(615) 741-0064

TennCare wants to know if there are actions we need to take to make sure that the MCOs and BHOs provide all covered services as required in their contract with the State. Please provide as much specific information as possible so that we can track down the cause of the problem quickly. **NOTE: TennCare enrollees have the right to appeal any action taken by the MCO or BHO to deny, reduce, terminate, delay, or suspend a covered service that is ordered or prescribed by a participating provider.**

# DCS Complaint Form

Child's name: \_\_\_\_\_

Child's TennCare ID Number: \_\_\_\_\_

Child's birthdate: \_\_\_\_\_

The child's *current* address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Current phone number where the child is living: \_\_\_\_\_

Child's MCO \_\_\_\_\_

Child's BHO \_\_\_\_\_

Child's PCP \_\_\_\_\_

- ☐ 1. I have tried to call the MCO or BHO about this child and I have had trouble getting through to them.  
The MCO/BHO I called was \_\_\_\_\_. The date of the call was \_\_\_\_\_. The length of time I had to wait on the phone before I got to talk to someone was \_\_\_\_\_. The length of time it took for me to get an answer to my question was \_\_\_\_\_.
- ☐ 2. I called the child's MCO to find out who the primary care provider (PCP) is for this child, but they could not tell me.  
The date I called was \_\_\_\_\_. The person at the MCO with whom I spoke was \_\_\_\_\_. The reason(s) they said they could not name a PCP for the child was/were: \_\_\_\_\_.
- ☐ 3. I called the PCP to get an appointment for the child. The PCP's office could not arrange a regular appointment within 3 weeks of my request and/or could not provide urgent care within 48 hours. I called the MCO for assistance, but they were unable to help.  
The type of appointment requested was \_\_\_\_\_ urgent \_\_\_\_\_ regular. The date the appointment was requested was \_\_\_\_\_, and the first appointment date they could offer was \_\_\_\_\_. The date I called the MCO was \_\_\_\_\_. The reason(s) they gave for being unable to help was/were: \_\_\_\_\_.

- ☐ 4. I have attempted to get a dental check-up for the child, but could not get a referral from the MCO to a dentist who was available to see her.

*The date I called the MCO for assistance was \_\_\_\_\_, and the person at the MCO with whom I spoke was \_\_\_\_\_. The reason(s) they gave for being unable to help was/were:*

- ☐ 5. I got the name of a dentist who can provide a check-up for this child, but the waiting time for an urgent appointment is longer than 48 hours and/or the waiting time for a regular appointment is longer than 3 weeks. I called the MCO for assistance.

*The type of appointment requested was \_\_\_\_\_ urgent \_\_\_\_\_ regular. The date the appointment was requested was \_\_\_\_\_. The first appointment date the dentist's office could offer was \_\_\_\_\_. The date I called the MCO for assistance was \_\_\_\_\_. The reason(s) they gave for being unable to help was/were:*

- ☐ 6. The child's PCP has recommended that the child see a specialist, but there have been delays in obtaining the specialist's services. The type of specialist that was recommended was:\_\_\_\_\_.

*The date the MCO/BHO was called for assistance was \_\_\_\_\_. The person at the MCO/BHO with whom I spoke was \_\_\_\_\_.*

*The delay was caused because the MCO/BHO was:*

- ☐ Unable to identify a specialist  
☐ Unable to assist the child in getting a regular appointment with a specialist within 3 weeks or an urgent appointment within 48 hours  
☐ Other: \_\_\_\_\_

- ☐ 7. I am having trouble getting services through the Mental Health Center for this child. The reason(s) I am having trouble is/are:

☐ There is a waiting list. The name of the Mental Health Center is \_\_\_\_\_ . The date an appointment was requested for this child was \_\_\_\_\_. The earliest appointment date they could offer was \_\_\_\_\_. The date the BHO was called for assistance was \_\_\_\_\_. The person at the BHO with whom I spoke was \_\_\_\_\_. The reason(s) the BHO gave for being unable to help was/were:

☐ Other:

- ☐ 8. Did you discuss this with your TennCare representative? \_\_\_\_\_

☐ The TennCare representative was unable to assist me. The reason(s) the TennCare representative was unable to help was/were:

**OTHER MCO/BHO PROBLEMS:**

Please be specific. Indicate what efforts have been made, who has been contacted, and the dates of these efforts and contacts.

Your name: \_\_\_\_\_

Your work address: \_\_\_\_\_

Telephone number(s) where you can be reached during business hours:

Date: \_\_\_\_\_

# **Attachment H**

## **MCO and BHO DCS Liaisons**

## MCO and BHO DCS LIAISONS

### **Access MedPlus**

**Dr. Barbara Nabrit-Stephens, Medical Director**

615-329-2016 ext.2259

Tennessee Coordinated Care Network  
205 Reidhurst Avenue, Suite N-104  
Nashville, TN 37203

### **BlueCare**

**Virginia Lewis**

423-755-5656

Volunteer State health Plan, Inc.  
801 Pine Street  
Chattanooga, TN 37402  
423-755-5656

### **John Deere Health Care**

**Courtney Hicks**

423-954-3438

*Chattanooga area*

John Deere Health Care  
Uptain Building  
5751 Uptain Road, Suite 102  
Chattanooga, TN 37411-5671

**Tracy Bower**

423-769-1535

*Knoxville area*

John Deere Health Care  
408 N. Cedar Bluff Road, Suite 400  
Knoxville, TN 37923

**John Deere Cont.**

**Rhonda Cole**

423-578-2035

*Kingsport area*

John Deere Health Care  
2578 East Stone Drive Suite A  
Kingsport, TN 37660-5847

**OmniCare Health Plan**

**Linda Hodge**

901-348-3309

**Patsy Haralson** (*Alternate*)

901-348-2208

OmniCare Health Plan  
1991 Corporate Avenue  
Memphis, TN 38132

**PHP TennCare**

**Carolyn Fulghum**

423-670-7338

Tennessee Health Partnership (delegated vendor)

**Mary D. Cogar**

423-670-7338

PHP TennCare

Preferred Health Partnership of Tennessee, Inc.  
P.O. Box 22949  
Knoxville, TN 37933-0049

**Prudential HealthCare Community Plan**

**Trezette Batchlor**

901-541-9395

Prudential Health Care Community Plan  
3150 Lenox Park Blvd., Suite 110  
Memphis, TN 38115-4299

## **TLC Family Care Healthplan**

**Berry Shelton**

800-473-6523 ext. 3156

**Edna Willingham** (*Aternate*)

800-473-6253 ext. 3020

Memphis Managed Care Corporation  
1407 Union Avenue, Suite 1100  
Memphis, TN 38107

## **Vanderbilt Health Plans**

**Thoris Campbell**

615-782-7903

Vanderbilt Health Plans  
706 Church Street, Suite 500  
Nashville, TN 37203

## **Xantus HealthPlan of Tennessee**

**Katherine (Kathy) Janutolo**

800-494-7129 ext. 7512

**Sheree Tochelle**

800-494-7129 ext. 7603

Xantus Corporation  
Health Services Department  
3401 West End Avenue Suite 470  
Nashville, TN 37203

## **Premier Behavioral Systems and Tennessee Behavioral Health**

**Mary Linden Salter**

West TN - Regions 6 and 7

615-743-2187

**Joan Harris**

Middle TN- Regions 4 and 5

615-313-5455

**Margaret Puckett**

East TN - Regions 1, 2 and 3

615-313-4495

AdvoCare of TN  
222 2<sup>nd</sup> Avenue North, Suite 220  
Nashville, TN 37201

# **Attachment I**

## **MCO and BHO EPSDT Coordinators**

# EPSDT COORDINATORS

Access MedPLUS	Andrea Thaler	615-255-2700 ext.1290
Blue Cross	Virginia Lewis	423-755-5656
John Deere	Leslee Edmondson	309-765-1553
OmniCare	Joyce Morgan	901-348-3350
Xantus	Marsha Groce	615-463-1541
PHP	Mary Cogar	423-670-7338
Premier/TBH	Melissa Isbell	615-743-2115
Prudential	Jamie Patterson	901-259-9219
TLC	Cheryl Henderson	901-725-7100 ext. 3101
Vanderbilt	Rich Mauriello	615-782-7950

*Updated June 14, 1999*

# **Attachment J**

## **Case Management Monitoring Plan**

**CASE MANAGEMENT REPORTING OF CONSUMERS DISCHARGED FROM  
PSYCHIATRIC FACILITIES/RESIDENTIAL TREATMENT FACILITIES (RTFs)**

**INPATIENT FACILITY / RTF**

Offer the consumer referral for case management based on priority status. (CRG 1, CRG 2, TPG 2)

Document on the TNCare BHO Discharge Summary/Plan the consumer's response to acceptance or refusal of the offer of a referral to case management.

Document on a Release of Information form consumer's acceptance or refusal of referral to case management.

Contact the identified CMHA to make the case Management referral and encourage the case manager to participate in the discharge planning process.

**The Inpatient Facility/RTF will:**

- Give the consumer educational material provided by the BHO on case management. If the consumer is a minor or an adult declared legally incompetent, the parent/legal guardian will act on the consumer's behalf regarding case management services.
- If the consumer agrees to a referral and is active in case management upon admission, contact the identified CMHA to ensure a case management encounter within seven days of discharge and to ensure the case manager's participation in the discharge planning process.
- If the consumer is not active in case management upon admission and agrees to a referral, the consumer will identify the case management agency of his/her choice.
- Upon acceptance of a referral to case management, obtain the consumer's signature on a Release of Information Form.
- If referral for case management is refused, document on the facility's Release of Information Form the signatures of the two staff members witnessing the consumer's refusal.
- The Release of Information Form will be filed in the consumer's medical record.
- Document on the TNCare BHO Discharge Summary/Plan the consumer's acceptance or refusal of case management referral.
- Document on the TNCare BHO Discharge Summary/Plan the assigned case manager and agency.
- Submit the TNCare BHO Discharge Summary/Plan to the Behavioral Health Organization within one business day of discharge.
- Forward a copy of the discharge summary to the CMHA/Case Manager.

**The Behavioral Health Organization will:**

- Request a Plan of Correction from the Inpatient Facility/RTF for failure to offer a referral for case management.
- Request a Plan of Correction for failure to identify the Community Mental Health Agency (CMHA) responsible for providing case management.
- Monitor consumers that refuse the referral for case management by identifying any barriers or trends related to the refusal of the referral for case management and develop interventions to improve outcome.
- Provide inpatient facilities/RTFs with educational materials for consumers on case management.
- Provide education and training to inpatient facilities/RTFs by way of conference calls, changes in written processes, any revised forms, etc.
- Request a Plan of Correction for failure to submit the TNCare BHO Discharge Summary/Plan to the BHO within one business day of discharge.

### **COMMUNITY MENTAL HEALTH AGENCY**

If the consumer is already active in case management, the case manager will have a face-to-face encounter with the consumer seven days prior or seven days following discharge and will be involved in the discharge planning process.

If the consumer is not active in case management, the case management agency chosen by the consumer will have a face-to-face encounter to offer case management services seven days prior or seven days following discharge.

If the consumer refuses case management services during the first face-to-face encounter, the consumer will sign a refusal form with one staff witness. If the consumer refuses to sign the refusal form, the refusal will be documented on the refusal form and witnessed by two staff members.

**The Community Mental Health Center will provide the following information to the appropriate BHO:**

- Consumers who have their first face-to-face case management encounter seven days prior or seven days following discharge.
- Consumers who have their first face-to-face case management encounter 8–21 days post discharge.
- Consumers who have no face-to-face case management encounter seven days prior or seven days following discharge.
- Consumers who accepted a referral for case management but refused case management at the first face-to-face encounter seven days prior or seven days following discharge. Submit to the BHOs the case management refusal forms that must be dated seven days prior or seven days following discharge.
- Consumers who have their first face-to-face case management encounter 21+ days post discharge.
- Consumers who did not have a face-to-face case management encounter but did receive another outpatient service within 14 days of discharges.
- Consumers who are clinically inappropriate for case management services.

**The following will be monitored by the BHOs for identifying barriers, but reported to the Bureau as no face-to-face case management encounter seven days prior or seven days following discharge.**

- Consumers who have their first face-to-face case management encounter 21+ days post discharge.
- Consumers who did not have a face-to-face case management encounter but did receive another outpatient service within 14 days of discharges.
- Consumers who are clinically inappropriate for case management services.

**The Behavioral Health Organization will:**

- Request a plan of correction from the identified CMHAs for consumers who accepted a referral for case management but the first face-to-face encounter occurred over seven days following discharge.
- Request a plan of correction from the identified CMHAs for consumers who accepted a referral for case management but the first encounter did not occur.
- Request a plan of correction from the CMHA for failure to submit refusal forms and case management information, e.g., adherence to appointments, rescheduling, etc. to the BHO on a daily basis or as requested.

### BUREAU OF TENNCARE

Establish a baseline indicator for referral to case management.

After six months of collecting data, establish a threshold for consumers receiving face to face case management encounters seven days prior or seven days post discharge.

Perform a monthly analysis of case management.

Conduct a monthly discharge planning audit.

Conduct a quarterly retrospective verification of case management encounter data.

#### **The Bureau of TennCare will:**

Implement this program beginning July 1, 1999; however, the minimum threshold of **seventy percent (70%)** will begin on September 1, 1999 for priority consumers (CRG 1, CRG 2, and TPG 2) who are offered a referral for case management by Inpatient Facility/RFT staff. The threshold percentage will **increase in increments over the next four months by five percent (5%) each month up to ninety (90%) effective January 1, 2000.** The percentage will remain as the acceptable threshold for the offer of a referral for case management.

#### **Indicator 1:**

**Numerator:** Number of consumers offered a referral for case management

**Denominator:** Total number of consumers discharged excluding judicials and state custody

After six months of collecting baseline data, a threshold percentage will be established on March 1, 2000 for the priority consumers who were referred for case management and received face to face case management encounter seven days prior or seven days post discharge.

#### **Indicator 2:**

**Numerator:** Number of consumers who received a face-to-face case management encounter seven days prior or seven days post discharge.

**Denominator:** Number of consumers who accepted a referral for case management excluding appropriately documented Refusals. (Refusals are the number of consumers who accepted a referral for case management but refused case management at the first face-to-face encounter seven days prior or seven days following discharge.

The following information will also be included in the Bureau of TennCare's Analysis:

- % of consumers who accepted a referral for case management and received face to face case management encounter within 8-21 days post discharge.
- % of consumers who accepted a referral for face to face case management but had no encounters.
- # of consumers who accepted a referral for case management but refused during first face-to-face encounter with the case manager. **This number will be excluded from the Denominator in Indicator 2.**

### REPORTING REQUIREMENTS

The BHO will submit a monthly Case Management Report to the Bureau of TennCare on the 15<sup>th</sup> of the second month following the reporting month according to the Bureau's format. The TennCare BHO Discharge Summary/Plans will be retained at the BHO and be available to TennCare for random sample reviews. A refusal form will be submitted for each consumer who accepted a referral for case management but refused case management at the first face-to-face encounter seven days prior or seven days following discharge.

The BHO will submit each month for the first three months (July-September 1999) and quarterly thereafter to the Bureau of TennCare an analysis of the data, actions taken during the month/quarter to improve the processes, follow-up/action items, a summary of provider plans of correction and identified barriers, and interventions taken by the BHOs to improve outcomes. The reporting dates for the above activities will be as follows: July report due September 15, 1999, August report due October 15, 1999, and September report due November 15, 1999. The quarterly report for October -December will be due on February 15, 2000. All quarterly reports will be due on the 15<sup>th</sup> of the second month following the reporting period.

#### **The Behavioral Health Organization will:**

- Provide monthly/quarterly reports identifying barriers related to consumers acceptance of the offer for a referral for case management, refusals of the offer for a referral for case management, and the consumers acceptance of a referral to case management but refused case management at the first face-to-face encounter with the case manager.
- Track all identified barriers in order to identify trends and make appropriate requests for corrective action by providers.
- Develop and implement interventions to improve the outcomes in acceptance of the offer for a referral for case management and the acceptance for those consumers who accepted a referral to case management but refused case management at the first face-to-face encounter with the case manager.
- Meet each month with the Bureau of TennCare to discuss the results of the analysis of the monthly case management report.

#### **The Bureau of TennCare will:**

- Verify the consumers in State custody.
- Verify the consumers in the Judicial classification.
- Verify the appropriate completion of the refusal forms for the consumers who accepted a referral to case management but refused case management at the first face-to-face encounter with the case manager.
- Verify appropriate case management documentation on the TennCare BHO Discharge Summary/Plan.
- Review monthly/quarterly reports and provide appropriate feedback to the BHOs as indicated.
- Meet each month with the BHOs to discuss the results of the analysis of the monthly case management report.
- Evaluate this process every six months in order to strengthen the program integrity effort.



# **Attachment K**

## **TennCare Standard Operating Procedure 036 and Addendum 1**



STATE OF TENNESSEE  
DEPARTMENT OF HEALTH  
BUREAU OF TENNCARE  
729 CHURCH STREET  
NASHVILLE, TENNESSEE 37247-6501

**MEMORANDUM**

DATE: *April, 1999*

TO: TennCare MCOs & BHOs

TSOP: 036

FROM: Brian Lapps, Sr.  
Director of TennCare

SUBJECT: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) is a required service under the Medicaid program for categorically needy individuals under age 21. The EPSDT benefit is optional for the medically needy population. However, if the EPSDT benefit is elected for the medically needy population, the EPSDT benefit must be made available to all Medicaid eligibles under age 21. Under its former Medicaid program, the State of Tennessee had already extended the EPSDT benefit to the medically needy population. The TennCare program extends the EPSDT benefit to also include the uninsured/uninsurable under age 21 population.

The purpose of this TSOP and subsequent addendums is to outline and explain the various requirements and responsibilities for assuring compliance with federal and state law concerning the EPSDT benefit under TennCare. Periodicity schedules and other items affecting EPSDT screens and treatments will also be addressed.

The EPSDT program consists of two (2) mutually supportive, operational components:

- (1) Assuring the availability and accessibility of required health care resources, and
- (2) Helping TennCare enrollees and their parents or other responsible parties effectively use those resources.

These components enable TennCare through the MCOs, BHOs, and the Department of Children's Services (DCS) to manage a comprehensive child health program of prevention and treatment and to systematically:

- ▲ Seek out eligibles and inform them of the benefits of prevention and health services and assistance available;
- ▲ Help them and their families use health resources, including their own talents and knowledge, effectively and efficiently;
- ▲ Identify the child's health needs through initial and periodic examinations and evaluation; and to
- ▲ Assure that health problems found are diagnosed and treated early before they become more complex and their treatment more costly.

While Title XIX establishes the framework of standards and requirements that must be met, the Bureau has the flexibility within the Federal statutes and regulations to design an EPSDT program that meets the health needs of its enrollees. The Bureau will work with the MCOs/BHOs and DCS to develop an EPSDT program that meets the requirements imposed by HCFA, as well as the EPSDT Consent Decree.

42 U.S.C. §§ 1396a(43), 1396d(a)(4)(B), and 1396d(r) set forth the basic requirements for the EPSDT program. Under the EPSDT benefit, TennCare, through its contractors, must provide for well-child screenings, vision, hearing, and dental screenings at the intervals recommended by the American Academy of Pediatrics (AAP). Interperiodic screenings are required outside the AAP periodicity schedule whenever health problems are suspected. Additionally, it is required that any service which the Bureau is permitted to cover under the federal Medicaid program that is necessary to treat or ameliorate a defect, physical or mental illness, or a condition identified by a screen, must be provided to EPSDT participants regardless of whether the service or item is otherwise included in Tennessee's Medicaid plan.

The Medicaid Act provides an exception to comparability for EPSDT. Under this exception, the amount, duration, and scope of the services provided under the EPSDT program are not required to be provided to other TennCare enrollees or outside the EPSDT benefit. Services under EPSDT must be sufficient in amount, duration, and scope to reasonably achieve their purpose. 42 C.F.R. § 440.230(b). The amount, duration, or scope of EPSDT services to enrollees may not be denied arbitrarily or reduced solely because of the diagnosis, type of illness, or condition. 42 C.F.R. § 440.230(c). Appropriate limits may be placed on EPSDT services based on medical necessity, including reasonable requirements for prior authorization and to implement tentative service limits. **However**, if a service is medically necessary and a covered service within its State contract, it must be provided by the MCO/BHO without regard to the tentative service benefits limits. Whenever an MCO or BHO

states that there is a tentative limit on EPSDT services, enrollees and providers must be told that, if medical necessity can be shown, such limit(s) can be waived. Medical necessity **must** be decided on a case-by-case basis.

Utilization controls cannot unreasonably delay the initial or continued receipt of services, nor can they cause enrollees to go without needed care. There must be an expeditious process in place to ensure that children receive, without interruption, any medically necessary services that exceed tentative limits. For example, an MCO may approve a block of six (6) physical therapy visits, the block of services is used up, and the MCO requires a whole new authorization process for the next block of PT, which could cause the child to go without services in the interim. If the provider requests continuation of the services before the end of an approved block of services, those services are to continue without interruption.

Any denial of a timely request from the provider who originally prescribed an ongoing service for continuation of the service beyond tentative limits shall be attended by notice to the enrollee prior to reduction or termination of the services. If the denial is appealed in a timely fashion, the services shall be continued pending appeal without regard to the MCO's tentative limits. A request from a provider for continuation of a service shall be considered timely if it is made prior to termination of the treatment interval previously approved by the MCO. A request from a provider for the continuation of services an enrollee is receiving shall not impact on the enrollee's own right to request a continuation of services pending the results of the enrollee's appeal, as stated in TennCare rule 1200-13-12-.11(2)(i). The Bureau will review the MCOs' prior approval/utilization review processes on an annual basis to assure that tentative limits approved by MCOs are appropriate.

When making medical necessity decisions, MCOs, BHOs and the Department of Children's Services must adhere to the definition of "Medically Necessary" as defined in the TennCare/MCO and TennCare BHO contracts and printed here.

**Medically Necessary** - shall mean services or supplies provided by an institution, physician, or other provider that are required to identify or treat a TennCare enrollee's illness, disease, or injury and which are:

- a) Consistent with the symptoms or diagnosis and treatment of the enrollee's illness, disease, or injury; and
- b) Appropriate with regard to standards of good medical practice; and
- c) Not solely for the convenience of an enrollee, physician, institution, or other provider; and

- d) The most appropriate supply or level of services that can safely be provided to the enrollee. When applied to the care of an inpatient, it further means that services for the enrollee's medical symptoms or condition require that the services cannot be safely provided to the enrollee as an outpatient; and
- e) When applied to enrollees under 21 years of age, services shall be provided in accordance with EPSDT requirements including federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989.

This should not be interpreted to limit the MCO's or BHO's ability to use or establish mechanisms to apply the TennCare contractual medical necessity definitions or to direct patients to medically appropriate, more cost effective alternatives, provided these services would adequately address the patient's medical needs.

As previously stated, the Bureau will be issuing addendums to this TSOP to further explain expectations for the EPSDT program under TennCare. MCO, BHO, and DCS input are welcomed.

**TennCare Authority:**

42 U.S.C. §§ 1396a(a)(43); 1396d(a)(4)(B); 1396d(r)  
42 C.F.R. § 440.230  
42 C.F.R. § 441, Subpart B  
HCFA's State Medicaid Manual  
TennCare Rules and Regulation 1200-13-12-.04(1)(w)  
TennCare/MCO Contract Section 2-3.a.1.; Section 4-8.  
TennCare/BHO Contract Section 2.6.1.; Section 5.3.3.1.

**TennCare Contact Person:**

Regarding -

Medical Issues -	Medical Director	(615) 741-0213
Quality of Services -	Quality Improvement	(615) 741-0192
Policy -	Ann Alderson	(615) 741-0160
Contract Compliance -	Steve Hopper	(615) 741-2290
EPSDT Coordinator -	Kasi Tiller	(615) 532-6089



STATE OF TENNESSEE  
DEPARTMENT OF HEALTH  
BUREAU OF TENNCARE  
729 CHURCH STREET  
NASHVILLE, TENNESSEE 37247-6501

**MEMORANDUM**

DATE: *April, 1999*

TO: TennCare MCOs & BHOs

TSOP: 036  
Addendum 1

FROM: Brian Lapps, Sr.  
Director of TennCare

SUBJECT: EPSDT Outreach and Informing Requirements

NOTE: The EPSDT outreach and informing requirements stated in this TSOP must be put in place as soon as possible by MCOs and BHOs and maintained thereafter. The Bureau of TennCare will inform all contractors of any changes that must be made in a timely manner. These changes may occur as a result in changes: in federal or state laws, made by HCFA, and/or the rules and regulations of the TennCare program.

I. General Information

The Bureau of TennCare and its MCOs and BHOs are required to inform all TennCare enrollees under age 21 about the availability of and how to access EPSDT services. There is flexibility in how this is accomplished as long as the outcome is effective and is achieved in a timely manner, generally within 60 days of the MCO's/BHO's receipt of notification of the child's TennCare eligibility. For Medicaid-eligible (DHS) enrollees, the process of informing will begin at the intake interview. Non-Medicaid and SSI eligibles will receive information in their "welcome" letter from TennCare about EPSDT. All eligibles will receive information from their assigned MCO/BHO.

Methods of communication used are to be such that enrollees can clearly and easily understand EPSDT, ensuring that they have the information they need to use services to which they are entitled. A combination of face-to-face, oral, and written informing activities have been shown to be the most effective methods. HCFA considers "oral" methods to include face-to-face informing by eligibility case workers, health aides, and providers, as well as public service announcements, community awareness campaigns, audio-visual films, and film strips.

## II. Individuals to be Informed About the EPSDT Program

- Inform all TennCare-eligible children under age 21 and their parents or other responsible parties;
- Inform newly eligible children under age 21 and their parents or other responsible parties, either determined eligible for the first time, or determined eligible after a period of ineligibility if they have not used EPSDT services for at least 12 months. Individuals/families that go on and off eligibility rolls should be informed at least once every 12 months;
- For children in institutions, notification is to include the administrator of the institution;
- Inform TennCare eligible pregnant women about the availability of EPSDT services for children under age 21 (including children eligible as newborns). A TennCare eligible woman's positive response to an offer of EPSDT services during her pregnancy, which is medically confirmed, constitutes a request for EPSDT services for the child at birth. For a child eligible at birth (i.e., as a newborn for a woman who is eligible for and receiving Medicaid), the request for EPSDT services is effective with the birth of the child. The parent or guardian of an infant who is not deemed eligible at birth as a newborn must be informed about the availability of EPSDT services at the time the infant's eligibility is determined.

## III. The Role Of the Bureau of TennCare

- A. The Bureau will work with other Bureaus within the Department of Health (TDH) and the local county health departments, the Department of Human Services (DHS), the Department of Children's Services (DCS), Local Education Agencies (LEAs), schools, day care centers, and other agencies, to inform an enrollee's parents or other responsible parties of the purpose and availability of EPSDT services. This does not replace nor relieve the MCOs or BHOs of their responsibilities to inform their enrollees of such services.

The Bureau will include in letters to new non-Medicaid enrollees the following statement concerning EPSDT:

**TennCare has a special program for children under age 21.** This program is called "EPSDT" (Early and Periodic Screening, Diagnosis, and Treatment). Your child's TennCare plan will do regular check-ups for your child. Then your child's TennCare plan and Partners plan will treat health, developmental, and behavioral problems that are found.

Call your child's main doctor or nurse for a checkup *anytime* you think your child may have a problem. If you don't know who your child's doctor is, or if your child's regular doctor does not do EPSDT checkups, call your TennCare plan for help.

**You also should take your child in for regular check-ups even when your child seems healthy.** These check-ups help us find problems early and treat them so that your child will stay healthy. If you need transportation to get to the doctor's office, call your TennCare plan for help.

EPSDT check-ups are **free**. They can help find problems such as:

Health problems	Eye problems
Hearing problems	Drug and alcohol problems
Slow development	Nerve problems
Dental problems	

If you have TennCare premiums, you will have your usual co-insurance payments on treatment services.

- B. The Bureau, through the Office of Contract Development and Compliance, will review all material - including but not limited to - mail outs to enrollees about EPSDT, statements in the members' handbook, promotional material, public service announcements, media advertisements, posters, etc. - before they are used by the MCO/BHO to inform enrollees about EPSDT services.
- C. The Bureau will gather, compile, and analyze all data from the MCOs and BHOs relating to MCO/BHO EPSDT outreach and information activities to educate enrollees. This information will be used to prepare and submit reports to the proper entities as required by HCFA and the Consent Decree. MCOs and BHOs shall provide such data to the Bureau annually on the calendar year basis (January - December). Failure to timely submit [within 90 days of the end of the year] the requested data may result in liquidated damages as described in the TennCare & MCO/BHO contracts.

MCOs and BHOs are expected to document to the Bureau their outreach activities and what efforts were made to inform enrollees and/or their parents or other responsible parties about the availability of EPSDT services and how to access such services. Information to be provided shall include what form of contact was used (i.e., special mailings, health fairs, etc.), the intended target audience (was the information sent to all enrollees or only those cases which included pregnant women, and/or children under 21), outreach/information activities coordinated with appropriate providers, public service announcements, etc. The Bureau encourages MCOs to make use of enrollee newsletters, as called for in the Contract Section 2-6.b.2., to communicate the importance of preventive health care and the use of EPSDT services.

- D. If the Bureau determines that an MCO or BHO has failed to reach particular groups of EPSDT-eligibles, the MCO or BHO shall be instructed to focus on particular "at risk" groups. Examples of such groups are, but not limited to, families with infants or adolescents, first time eligibles, those not using the EPSDT program for over two (2) years, and families participating in the WIC program.

#### IV. The Role Of MCOs & BHOs

BHOs are responsible for providing mental health and substance abuse services to TennCare enrollees under the age of 21. MCOs are responsible for providing all other EPSDT services to TennCare enrollees under the age of 21. Requirements such as amount, scope, and duration are applicable equally to MCOs and BHOs.

MCOs/BHOs are responsible for informing and outreaching their enrollees with regard to EPSDT benefits provided through their respective plans.

##### A. Contents and Methods

1. EPSDT information sent to eligibles and their families or other responsible parties shall emphasize that preventive health care is provided to all TennCare enrollees at no cost to the enrollee. Additionally, that prior authorization is not required in order to obtain EPSDT screening services provided by a participating provider.
2. MCOs and BHOs shall aggressively and effectively inform all TennCare enrollees about the existence and availability of EPSDT services for those under age 21. The notice is to include information about the availability of specific EPSDT screening and treatment services.
3. Notice shall be given in a timely manner, generally within 60 days of the TennCare MCO's receipt of notification of the child's enrollment in its plan. This information shall be issued no less often than annually.
4. MCOs/BHOs shall use clear and non-technical terms to provide a combination of written and oral information so that the program is clearly and easily understood. Materials used in this process shall continue to be prepared at the 6<sup>th</sup> grade level as determined by the Flesch-Kincaid Index, Flesch Index, or the Fog Index. Such information shall include the following: (a) the benefits of preventive health care; (b) the services available under the EPSDT program and where and how to obtain those services; (c) the recommended frequency of EPSDT checkups, with additional information that screens can be requested anytime a parent, teacher, or someone else involved with the child thinks there is a problem; (d) that the preventive services provided under the EPSDT program are without cost to enrollees; and (e) that necessary transportation and scheduling assistance are available to EPSDT eligibles upon request.

5. MCOs/BHOs shall use accepted methods for informing persons who are illiterate, blind, deaf, or cannot understand the English language about the availability and use of EPSDT services. Lacking in-house expertise in these areas, MCOs /BHOs should work in collaboration with agencies which have established procedures for working with such individuals.

#### B. Additional Outreach Requirements

1. MCOs/BHOs shall establish a system whereby families can readily access an accurate list of names and telephone numbers of contract providers who are currently accepting TennCare. This system shall also indicate which providers may perform EPSDT screens.
2. MCOs/BHOs shall offer and provide enrollees with assistance in scheduling appointments and obtaining transportation prior to the date of each periodic examination as requested and necessary.
3. MCOs/BHOs shall document services declined by a parent, guardian, or mature competent child<sup>1</sup>, specifying the particular service declined so that outreach and education for other EPSDT services continue. MCOs/BHOs may either maintain such information themselves or opt to require their network providers to maintain such information in the patient's medical file.
4. MCOs/BHOs shall maintain records of the efforts taken to reach out to children who have missed screening appointments when scheduled or who have failed to schedule regular check-ups.

#### V. The Role of the Local County Health Department

The local county health department shall provide information on EPSDT and other covered services to adolescent prenatal patients who enter TennCare through presumptive eligibility. Assistance shall also be offered to these patients in making a timely first prenatal care appointment. For a woman past her first trimester, this appointment should occur within 15 days. MCOs may want to consider establishing an internal contact point to aid the county health offices in identifying providers who are taking new patients and to offer other assistance as necessary.

Local county health departments shall also provide information about EPSDT benefits to uninsured/uninsurable applicants when assisting them in applying for TennCare.

## VI. The Role of the Department of Children's Services (DCS)

Where eligible enrollees in State custody live in institutions or other residential treatment settings, other than with their natural or adoptive parents, DCS shall inform the institution/residential treatment program annually as to the benefits of the EPSDT program, or more often when the need arises, including when a change of administrators, social workers, or foster parents occur.

## VII. Compliance

All MCOs and BHOs must document and maintain records of all outreach efforts made to inform enrollees about the availability of EPSDT services.

<sup>1</sup> A "mature competent child" is defined as a minor who has the capacity to consent to and appreciate the nature, the risks, and the consequences of the medical services involved. Recognizing that minors achieve varying degrees of maturity and responsibility (capacity), the mature minor exception is also guided by the Rule of Sevens which provides as follows: under the age of seven (7), no capacity; between seven (7) and fourteen (14), a rebuttable presumption of no capacity; between fourteen (14) and twenty-one (21), a rebuttable presumption of capacity. (*Cardwell v. Bechtol*, Tennessee Supreme Court, 724 S.W.2d (Tenn. 1987))

### TennCare Authority:

42 U.S.C. §§ 1396a(a)(43); 1396d(a)(4)(B); 1396d(r)  
42 C.F.R. § 440.230  
42 C.F.R. § 441, Subpart B  
HCFA's State Medicaid Manual  
TennCare Rules and Regulation 1200-13-12-.04(1)(w)  
TennCare/MCO Contract Section 2-3.a.1.; Section 4-8.  
TennCare/BHO Contract Section 2.6.1.; Section 5.3.3.1.

### TennCare Contact Person:

Regarding -

Medical Issues:	Medical Director	(615) 741-0213
Quality of Services:	Quality Improvement	(615) 741-0192
Policy:	Ann Alderson	(615) 741-0160
Contract Compliance:	Steve Hopper	(615) 741-2290
EPSDT Coordinator:	Kasi Tiller	(615) 532-6089

# **Attachment L**

## **Review of Appeals**

## MEMO

To: Ms. Susie Baird  
Bureau of TennCare

From: Marguerite Lewis  
Office of Policy Planning and Assurance

Date: July 26, 1999

Re: EPSDT REPORT (January – June 1999)

*The number of appeals reflected may not include all appeals received during this time period as these numbers are dependent on the date of entry and the date of the data pulls. Data for this report was pulled July 14, 1999.*

For each MCO/BHO, the table below reflects the total number of children's appeals for January – June 1999. *Note:* Under normal circumstances, this report would include the rate of appeals per 10,000 children enrolled, which would provide a common metric on which each MCO/BHO could be compared. As the required numbers could not be obtained, only the raw numbers (not rates) are provided and they should not be used to make comparisons across MCOs/BHOs.

MCO/BHO	January – June, 1999 TOTAL # OF CHILDREN'S APPEALS
Access...MedPlus	54
BC/BS, THP	138
Heritage	7
Omni-Care	3
Xanthus	46
PHP	38
Prudential	2
TLC	7
VHP	2
TOTAL	297
Premier	82
TBH	81
TOTAL	163
GRAND TOTAL	460

Based on a compilation of **Service appeals** data for January - June 1999, there were a total of 460 appeals filed on behalf of children (under 21 years of age). Three hundred and sixty-four (364) were regular appeals and 96 were expedited appeals. Medical necessity was determined in 404 appeals, no medical necessity was decided on 37, and 19 appeals were withdrawn by the enrollee. Sixty-eight (68) appeals are still pending a final resolution.

### CARE TYPES

Children's appeals included 22 Service Types. The Service Types with the highest number of appeals are: Residential Treatment (75), Durable Medical Equipment (55), Pharmacy (47), Dental (45), Other (37), MH-Outpatient (33), MH-Inpatient (32), Access to Services (32), and Home Health (30).

Additional Care Types include: Procedure (20), Physician (15), Eligibility (13), Physical Therapy (9), Nutritional (5), Speech Therapy (4), Vision (2), Quality Improvement (1), TPG-Add (1), A & D Inpatient (1), Anesthesia (1), Chiropractic (1), and Hospital-Outpatient (1).

# TYPE OF SERVICES, MCO/BHO

This table illustrates, by MCO/BHO, the type of service appeals and number for each type.

MCO/BHO NAME	TYPE OF SERVICE
Access Med Plus	Dental (8), Pharmacy (8), Access to Service (7), Other (7), DME (6), Home Health (6), Eligibility (4), Physician (4), Hospital-Outpatient (1), Physical Therapy (1), Procedure (1), and Quality (1)
Blue Cross/Blue Shield, THP	Dental (21), DME (21), Home Health (21), Pharmacy (17), Access to Services (14), Other (11), Procedure (11), Physician (8), Physical Therapy (5), Speech Therapy (3), Eligibility (2), Anesthesia (1), Chiropractic (1), TPG-Add (1), and Vision (1)
Heritage	Dental (2), DME (2), Other (2) and Nutritional (1)
Omni-Care	Eligibility (1), Physical Therapy (1), and Procedure (1)
Xanthus	Other (10), Access to Services (6), Dental (6), Eligibility (6), Procedure (6), Nutritional (3), Pharmacy (3), Home Health (2), DME (1), Physical Therapy (1), Physician (1), and Vision (1)
Preferred Health Partnership	DME (23), Dental (4), Pharmacy (3), Other (2), Physician (2), Home Health (1), Nutritional (1), Procedure (1), and Speech Therapy (1)
Prudential Community Care	Dental (1) and DME (1)
TLC Family Care Health Plan	DME (3), Other (3), and Access to Services (1)
VHP Community Care	DME (1) and Physical Therapy (1)
Premier Behavioral Systems	Residential Treatment (36), MH-Inpatient (17), MH-Outpatient (14), Pharmacy (8), Access to Services (4), Other (2), and A & D Inpatient (1)
Tennessee Behavioral Health	Residential Treatment (39), MH-Outpatient (19), MH-Inpatient (15), Pharmacy (8)

# APPEALS RESOLUTIONS

MCO/BHO DECISION	TOTAL	DOH DECISION	TOTAL
Affirmed	160	Affirmed	42
		Case Withdrawn by Enrollee	6
		Informal Resolution by Agreement	4
		Reversed	86
		Pending	22
Total	160	Total	160
Case Withdrawn by Enrollee	5	No Decision Required	5
Informal Resolution by Agreement	77	No Decision Required	77
Reversed	138	No Decision Required	138
Total	220	Total	220
No Reconsideration Response	80	Affirmed	0
		Case Withdrawn by Enrollee	7
		Informal Resolution by Agreement	2
		Reversed	3
		Pending DOH Decision	68
Total	80	Total	80
GRAND TOTAL	460	GRAND TOTAL	460

If you have any questions regarding this data, please feel free to call me at 532-6566.

MCO/BHO

# EPSDT

ACTIVITIES

REPORT

**EXTERNAL QUALITY REVIEW  
ORGANIZATION**

**First Mental Health**

**JANUARY 31, 1999**

## Introduction

EPSDT, a federally mandated component of the TennCare program, defines a comprehensive set of preventive and health care services that must be provided to TennCare eligible individuals under age 21. TennCare is not only required to provide this broad range of health services, but also to impose reporting requirements for EPSDT activities and to inform EPSDT eligible individuals (and their families) about the EPSDT program through written and oral outreach activities.

There are roughly 500,000 children enrolled in TennCare. The majority of these children are poor and qualify for coverage because they satisfy the eligibility criteria established by Title XIX. An additional 383,000 children qualify for EPSDT services under the special terms of the TennCare Waiver (Semiannual Progress Report, EPSDT Consent Decree pp. 3-4, July 1998). With 883,000 children eligible, EPSDT has the potential to substantially improve the overall health of Tennessee's children.

In February 1998, an action brought on behalf of all present and future TennCare beneficiaries under the age of 21, challenged the adequacy of children's health services provided by TennCare and the Tennessee Department of Children Services (DCS). This action created the opportunity, as well as, the necessity to monitor the impact of TennCare on the quality of care provided to children. Negotiations among advocacy groups, TennCare, and DCS representatives resulted in a Consent Decree outlining activities to be undertaken by the State to assure compliance with federal EPSDT requirements.

## Purpose

In a letter dated March 11, 1998, the Bureau of TennCare requested First Mental Health, the External Quality Review Organization (EQRO) for the TennCare program, to play a role in implementation of the Consent Decree. Assistance was requested to help assure participating managed care organizations (MCOs) and behavioral health organizations (BHOs), hereafter referred to as organizations, were taking appropriate steps to bring TennCare in compliance with the provisions of the order. The letter specified the EQRO role in monitoring the organizations' performance in areas identified in paragraphs 39, 40, 53-59, and 74-77 of the Consent Decree.

## Methodology

The EQRO initially performed a comprehensive desk review of referral policies and procedures utilized by organizations as outlined in paragraph 53 of the Consent Decree. This activity was completed and a report was issued to TennCare on July 2, 1998.

Subsequently, the EQRO developed a tool and accompanying guidelines to measure compliance within the remaining assigned sections of the Decree. These materials were submitted to TennCare for approval, requested modifications were made, and final approval for the tool was obtained.

In conjunction with TennCare, it was determined the best method for gathering and validating (where possible) this significant amount of information, was to coordinate this assignment with other MCO and BHO reviews scheduled for the fall of 1998.

Experienced EQRO staff members were selected and trained to gather information through defined interviews with staff members, review of specified documents, and direct observation of utilization review staff. In order to assure consistency in compilation of the necessary information, the tool contained detailed instructions to the EQRO site review staff.

On-site reviews were initiated beginning in September 1998 and ended the second week of January 1999. Site visits were performed at each of the nine current MCOs and the two current BHOs. Information related to Tennessee Health Partnership, a subcontractor of Blue Cross, was gathered as part of the review conducted at Blue Cross and was incorporated into a composite report of the two organizations. Due to the merger of Tennessee Behavioral Health (TBH) into the Magellan network, information from both behavioral organizations was presented as a single BHO under the Premier name.

Once all on-site reviews were completed, the information was compiled and this report was written and produced. The report outlined details of findings, samples of specific or unusual findings, and some obvious conclusions in regard to the findings. Charts and tables were utilized to display findings in an easy to interpret format

Attachments to the report include:   Appendix A: On-site Tool  
  Appendix B: Definitions

## EPSDT Consent Decree, paragraph 39-40 — Outreach and Informing

Organizational efforts to inform members, providers, and staff about EPSDT varied broadly from organization to organization. While there were many efforts to distribute information to members, the success of mailing processes was uncertain. There were no tracking mechanisms in place to determine if mailings were received. Returned mailings were not routinely reviewed for address corrections.

All member outreach programs presented in 1998 were reviewed. Preventive services was the most common focus of community endeavors taken to educate members. Attendance was not consistently measured and the organizations did not attempt to measure the impact of their programs.

Member newsletters and other mailings utilized by the organizations in 1998 were numerous and addressed a wide variety of EPSDT subjects. All documents were written in clear and non-technical language. Staff of most organizations verbalized concerns regarding availability of accurate/current addresses.

Exhibits 1a. – 1j. display the subject types, methods of outreach efforts performed in 1998, and the target audience(s) for each effort.

### Exhibit 1a. OmniCare

Subject	Mailing		Brochure		Community Program	
	Member	Provider	Member	Provider	Member	Provider
EPSDT services (screening)	X	X			X	
Head to Toe Physical	X					
Eye Exam	X					
Hearing exam	X					
Nutrition check						
Growth and development check	X					
Blood and urine test	X					
Immunizations, if needed	X	X	X		X	
Informing families of the cost, if any	X					
Declining EPSDT services						
Appointment scheduling/transportation assistance						
Related transportation services, which include meals and lodging and the cost of an attendant						
Accessing services	X					
Prenatal care for pregnant adolescent (including request of EPSDT services for child at birth)			X		X	
Preventive services		X				
Dental check	X	X				
Referral for treatment as the result of screening						
Limits on services						

## Exhibit 1b. PHP

Subject	Mailing		Brochure		Community Program	
	Member	Provider	Member	Provider	Member	Provider
EPSDT services (screening)	X	X				X
Head to Toe Physical	X	X				X
Eye Exam		X				X
Hearing exam	X	X				X
Nutrition check						
Growth and development check	X	X				X
Blood and urine test	X	X				X
Immunizations, if needed		X				
Informing families of the cost, if any						
Declining EPSDT services						
Appointment scheduling/transportation assistance	X					
Related transportation services, including meals, lodging & cost of an attendant						
Accessing services	X					
Prenatal care for pregnant adolescent (including request of EPSDT services for child at birth)	X	X				
Preventive services	X	X				
Dental check	X					
Referral for treatment as the result of screening	X					
Limits on services	X					

## Exhibit 1c. Xantus

Subject	Mailing		Brochure		Community Program	
	Member	Provider	Member	Provider	Member	Provider
EPSDT services (screening)	X	X	X		X	X
Head to Toe Physical	X	X	X			
Eye Exam	X	X	X			
Hearing exam	X	X				
Nutrition check	X					
Growth and development check	X	X				
Blood and urine test	X	X			X	
Immunizations, if needed	X	X			X	
Informing families of the cost, if any	X					
Declining EPSDT services						
Appointment scheduling & transportation assistance	X					
Related transportation services, including meals, lodging, & the cost of an attendant	X	X			X	
Accessing services	X	X				
Prenatal care for pregnant adolescent (including request of EPSDT services for child at birth)						
Preventive services	X	X	X		X	
Dental check						
Referral for treatment as the result of screening	X	X				
Limits on services						

# Exhibit 1d. VCC

Subject	Mailing		Brochure		Community Program	
	Member	Provider	Member	Provider	Member	Provider
EPSDT services (screening)	X					
Head to Toe Physical	X					
Eye Exam	X					
Hearing exam						
Nutrition check						
Growth and development check	X					
Blood and urine test						
Immunizations, if needed	X					
Informing families of the cost, if any	X					
Declining EPSDT services						
Appointment scheduling & transportation assistance	X					
Related transportation services, including meals, lodging, & cost of an attendant						
Accessing services	X					
Prenatal care for pregnant adolescent (including request of EPSDT services for child at birth)						
Preventive services	X					
Dental check	X					
Referral for treatment as the result of screening	X					
Limits on services						

# Exhibit 1e. John Deere

Subject	Mailing		Brochure		Community Program	
	Member	Provider	Member	Provider	Member	Provider
EPSDT services (screening)	X	X				
Head to Toe Physical	X	X				
Eye Exam	X	X				
Hearing exam	X	X				
Nutrition check	X	X				
Growth and development check	X	X				
Blood and urine test	X	X				
Immunizations, if needed	X	X				
Informing families of the cost, if any						
Declining EPSDT services						
Appointment scheduling & transportation assistance	X	X				
Related transportation services, including meals, lodging, & cost of an attendant						
Accessing services	X	X				X
Prenatal care for pregnant adolescent (including request of EPSDT services for child at birth)						
Preventive services	X	X				
Dental check	X	X				
Referral for treatment as the result of screening	X	X				
Limits on services	X					

## Exhibit 1f. Prudential

Subject	Mailing		Brochure		Community Program	
	Member	Provider	Member	Provider	Member	Provider
EPSDT services (screening)	X	X				
Head to Toe Physical	X					
Eye Exam	X					
Hearing exam	X					
Nutrition check						
Growth and development check	X					
Blood and urine test	X					
Immunizations, if needed	X				X	
Informing families of the cost, if any						
Declining EPSDT services						
Appointment scheduling and transportation assistance						
Related transportation services, including meals, lodging, & cost of an attendant						
Accessing services	X					
Prenatal care for pregnant adolescent (including request of EPSDT services for child at birth)						
Preventive services	X					
Dental check	X					
Referral for treatment as the result of screening						
Limits on services						

## Exhibit 1g. BCBS

Subject	Mailing		Brochure		Community Program	
	Member	Provider	Member	Provider	Member	Provider
EPSDT services (screening)	X	X				
Head to Toe Physical		X				
Eye Exam	X	X				
Hearing exam	X	X				
Nutrition check						
Growth and development check	X	X				
Blood and urine test	X	X			X	
Immunizations, if needed	X	X			X	
Informing families of the cost, if any	X					
Declining EPSDT services						
Appointment scheduling & transportation assistance	X	X				
Related transportation services, including meals, lodging, & cost of an attendant						
Accessing services	X	X				
Prenatal care for pregnant adolescent (including request of EPSDT services for child at birth)	X	X				
Preventive services	X					
Dental check	X	X				
Referral for treatment as the result of screening	X	X				
Limits on services						

## Exhibit 1h. Premier

Subject	Mailing		Brochure		Community Program	
	Member	Provider	Member	Provider	Member	Provider
EPSDT services (screening)	X	X				
Head to Toe Physical						
Eye Exam		X				
Hearing exam		X				
Nutrition check						
Growth and development check						
Blood and urine test						
Immunizations, if needed						
Informing families of the cost, if any		X				
Declining EPSDT services						
Appointment scheduling & transportation assistance	X				X	
Related transportation services, including meals lodging, & cost of an attendant	X					
Accessing services	X	X			X	
Prenatal care for pregnant adolescent (including request of EPSDT services for child at birth)						
Preventive services						
Dental check		X				
Referral for treatment as the result of screening	X	X			X	
Limits on services	X	X				

## Exhibit 1i. Access MedPlus

Subject	Mailing		Brochure		Community Program	
	Member	Provider	Member	Provider	Member	Provider
EPSDT services (screening)	X				X	
Head to Toe Physical						
Eye Exam		X			X	
Hearing exam					X	
Nutrition check	X				X	
Growth and development check					X	
Blood and urine test						
Immunizations, if needed	X		X		X	
Informing families of the cost, if any					X	
Declining EPSDT services						
Appointment scheduling & transportation assistance						
Related transportation services, including meals and lodging, & cost of an attendant						
Accessing services						
Prenatal care for pregnant adolescent (including request of EPSDT services for child at birth)		X			X	
Preventive services	X	X			X	
Dental check		X			X	
Referral for treatment as the result of screening					X	
Limits on services					X	

# Exhibit 1 j. TLC

Subject	Mailing		Brochure		Community Program	
	Member	Provider	Member	Provider	Member	Provider
EPSDT services (screening)	X	X	X			
Head to Toe Physical		X				
Eye Exam	X	X	X			
Hearing exam	X	X	X			
Nutrition check		X				
Growth and development check	X	X	X			
Blood and urine test	X	X	X			
Immunizations, if needed	X	X	X			
Informing families of the cost, if any	X					
Declining EPSDT services						
Appointment scheduling & transportation assistance	X	X				
Related transportation services, including meals and lodging, & cost of an attendant						
Accessing services	X		X			
Prenatal care for pregnant adolescent (including request of EPSDT services for child at birth)	X	X	X			
Preventive services	X	X				
Dental check	X	X	X			
Referral for treatment as the result of screening	X	X	X			
Limits on services	X					

Attempts to disseminate EPSDT information to the member and provider populations varied greatly among the organizations. While emphasis appeared to be directed toward members, the majority of organizations made some attempts to inform providers. However, findings reflected minimal effort at provider education by two organizations. The absence of activities to monitor/measure the impact of these efforts on either population precluded assessment by the organizations of which efforts were most effective.

EPSDT elements commonly not addressed in organizational education/outreach materials were as follows: nutrition check; blood and urine test; declining EPSDT services; appointment scheduling and transportation assistance; related transportation services, including meals, lodging, and cost of an attendant; and prenatal care for pregnant adolescents and services for children at birth.

Standardized questions were posed during interviews with each organization's medical director(s), utilization managers, quality improvement manager, physician reviewers, UR clinical and non-clinical staff, and MIS staff. The following table summarizes the responses.

**Exhibit 2. Results of Staff Interviews**

Questions	MCOs										BHO
	Omni	John Deere	BC/BS	VCC	AMP	PHP	TLC	Prudential	Xantus	Premier	
Agencies assisting with blind, deaf, illiterate, or foreign languages?	Catholic Charities	Community Resources Manual	Inter-agency Council	None, developing a task force	TDD Language line	TDD	Alliance for Blind	TDD Language line	Spanish deaf resource file	TDD Language line	
A member/event specific reminder system?	No	No	Event specific	Member specific	Event specific	No	Event/Member specific	Member specific	Event specific	N/A	
Receipt of routine reports of members under 21?	No	No	No	No	No	Yes	No	No	No	No	
Provide members with EPSDT information?	Yes	Yes	Yes	Yes – but not vision	Yes	Yes	Yes	Yes	Yes	Yes	
Targeted information to high risk members & families?	Yes	No	Yes	No	Yes	No	No	Yes	No	No	
System to identify members who are hearing or visually impaired?	Blind-yes Hearing-No	No	No	No	No	No	No	No	No	No	
Systems to track members who speak a language other than English?	No	No	No	No	No	No	Yes	No	No	No	

As seen from the above table only one organization can identify its members with special needs such as hearing, vision, and language. Therefore, they have no way of knowing how extensive the needs may be or the extent to which the special need may affect accessing needed EPSDT services.

Although all organizations were performing EPSDT outreach and informing activities, the activities generally did not address all elements of EPSDT or target all populations.

## Consent Decree, paragraphs 54-59 — Utilization Review Processes

Policies, procedures, and processes were reviewed at each organization to assure that current utilization controls did not unreasonably delay the initial or continued receipt of services or cause recipients to go without medically necessary care. In addition to policies and procedures, documents supplied to members or providers, EPSDT educational material for review staff, denial logs and files, and review staff qualifications were examined. Logs of complaints and appeals were scheduled for review, however these logs were not consistently available for review. In most cases each organization's policies and procedures clearly outlined the authorization process. No deviations from the written documents were noted during the observation portion of this review.

Continued review of policies and procedures revealed that while all organizations denied that limits were placed on EPSDT services, limits were listed in member and provider handbooks for six organizations. Limits were placed in some organizations on some or all of the following; chiropractic services, dental and vision services, cardiac rehabilitation visits, diet instruction sessions, or physical therapy services. Actual application of limits was noted in only two files for diet instructions and cardiac rehabilitation. It should be noted that files were not always available for review and actual application of limits might be higher. Review staff at three of six organizations indicated all limits were tentative and did not apply to the under 21 population.

Prior authorization of periodic or interperiodic screening performed by the primary care physician for those under 21 was not required by any organization. Five organizations facilitated the referral process by allowing direct referrals to the next level of care by the primary care provider (PCP). All authorization systems were accessible toll free. All telephone lines were staffed during normal business hours and instructions were provided for after hours calls. To expedite the reauthorization process, all organizations accepted information from anyone with knowledge of the member/treatment plan rather than directly from the physician. Reauthorization of ongoing services was reportedly viewed as a continuation of service and not a separate service. However, organizations produced a limited number of under 21 files for review to verify this information. Of note were the following individual findings:

- One organization established guidelines requiring six episodes of tonsillitis in 18 months or complications before a member could be referred to an ENT by the PCP.
- Psychological testing was authorized in different manners by MCO staff. Five of the organizations approved initial psychological testing, while the remaining organizations referred members directly to the BHO.
- Two organizations appeared to delay services when coordination was required between the dental vendor and the organization.

Most organizations had a mechanism in place to verify licensure and job qualifications of their review staff. However, one organization did not have a written policy and files were kept off-site at their corporate location. The remaining files indicated all nurse reviewers had appropriate licensure and met job qualifications. All organizations stated they employed licensed personnel to make utilization determinations. All organizations could produce evidence that their medical directors were licensed except one.

## Denials

A major portion of the review focused on service denials to determine if inappropriate reasons were utilized to deny services and to determine if inappropriate denials were appealed. This objective was not reached due to organizational documentation processes. Denial documentation for the under 21 population was difficult to obtain as most organizations did not maintain denial logs or the logs presented did not reflect the member's age. Denial claims and services were often recorded on the same log. In order to select files for this review the organizations produced ad hoc reports printed exclusively for this purpose. In some cases non-age specific logs were produced. Denial documentation was also viewed on screen in computerized authorization systems. A total of 374 denial files were reviewed.

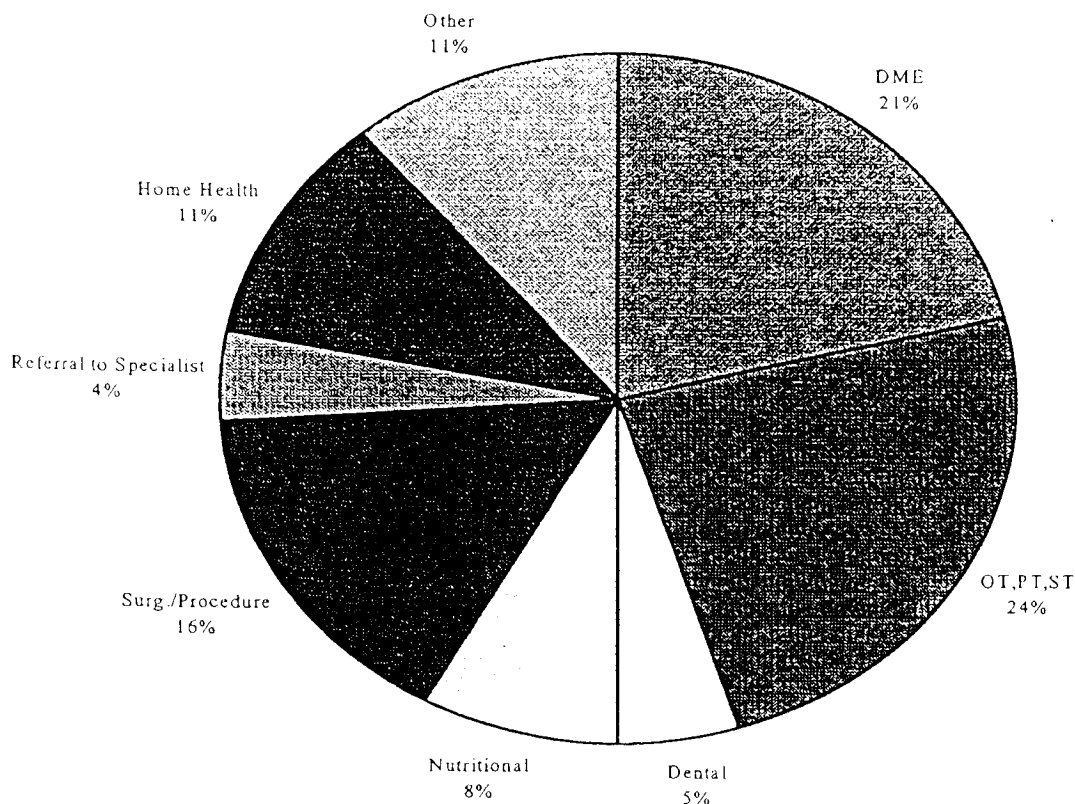


Exhibit 3 displays the distribution of types of denials by service.

## Denials, continued

Interviews with review staff indicated they clearly understood and promptly made appropriate referrals to physician reviewers when unable to authorize services based on written criteria. At six organizations the contractual definition of "medical necessity" was noted in provider manuals, member handbooks, and policies and procedures. At the other organizations, the intent to publish the definition was verbalized. All medical directors verbalized awareness of the current definition.

Requests for PT/OT/ST services in some long-term cases were denied based on the organization's determination that the service was not medically necessary. In these cases the member's condition was deemed "plateaued" due to the chronic nature of the condition and the improbability of improvement in health status. One medical director stated to the surveyor, "Plateaued cases of long term PT and OT are the most usual denials." There was no evidence of a system in place for reevaluation of the member's status to determine if the condition had deteriorated after the service was discontinued. Denial comments from physician reviewers noted in files included:

- "speech therapy is not covered as medically necessary if it is not restorative" (6 year old)
- "treatment plateaued with therapy, consider educational training" (OT/ 3 year old)
- "should not need PT in young, otherwise healthy individual" (PT for 15 year old with thoracic sprain, symptomatic x's 4 months)
- "medical necessity not justified because the mother is non-compliant with scheduled appointment" (PT for 4 year old)
- "ST not available for habilitative problems" ( ST for 2 year old)

Copies of two denial letters to members under 21 stated the reason for service denial was, "Therapy shall include functional, physical, and occupational therapy to the extent such therapy is performed to regain use of the upper and lower extremities." The same organization also included this statement in a draft policy for PT/OT/ST.

Eight files reviewed denied PT/OT/ST services indicating the requested therapy was available through school programs; however, there was no evidence of contact with school staff or verification that services were available in the school system.

Denials of homebound services did not reflect coordination efforts to provide services in another setting.

Requests for circumcision for children over 2 weeks of age were noted as denied at one organization. The organizational's medical director stated to the surveyor, "most doctors are not performing circumcisions while the newborn is in the hospital to cut costs." Written explanation of the denials cited the risk of anesthesia to the child as the reason for denial.

## Denials, continued

Services denied as non-covered included inpatient rehabilitation, chiropractic services, diapers for children under 3 years of age, nutritional supplements, and cosmetic surgery. One cosmetic denial was a request for bilateral otoplasty with unfolding helix for an 8-year-old with prominent ears. The mother reported concern as her child was being ridiculed at school. Utilization review staff at two organizations stated non-coverage is not handled as a denial and no denial letters are issued to members or providers.

The number of denial files available for review varied from 5 to 100 per organization. The organizations' inability to produce denial logs and identify members by age limited the review process. One organization presented an appeal log (primarily claims related) when a denial log was requested. Of the files reviewed PT, OT, and speech therapy were the services most frequently denied, but the significance of this finding is uncertain due to the limited files reviewed. Failure to coordinate services with schools and other providers was evident in the files reviewed.

## Consent Decree, paragraph 31-32, 78-80 — MCO/BHO/DCS Coordination

An effort to improve MCO/BHO/DCS coordination was noted at many of the organizations. Two organizations reported inservice training participation that included DCS staff. Three organizations had assigned case managers specifically to coordinate children's services. One organization established a 24-hour, 7-day a week authorization service to facilitate care for DCS/at risk members. One organization created a staff position to facilitate coordination with DCS; however, the position was vacant. One organization appointed a coordination committee to act as a liaison with DCS, but staff report indicated that as of December 1998, the committee had not met.

Significant concerns regarding the coordination of information and services between the organizations and DCS were revealed. While there were no mechanisms or systems presented that could identify children at risk of entering state custody, an issue of greater concern for the organizations was their inability to track children already in the state's care. Staff acknowledged that they received monthly lists from DCS; however, the information provided was not always an accurate reflection of a child's current placement. One case manager assigned to monitor 300 children verbalized the challenge of tracking children as the MCO was not always notified when changes in placement occurred. Review of denial files for this population did reflect that interruptions and discontinuation of services had occurred, and in part, was due to the inaccuracy of shared information.

Exhibit 4 represents the organizations with a designated contact person to facilitate communication.

Activity	MCOs									BHO
	Omni	John Deere	BC/BS	VCC	AMP	PHP	TLC	Prudential	Xantus	Premier
Mechanism in place to track continuity of care for DCS/at risk	None at time of survey.	Case managers	Case manager	None at time of survey	Project Teach juv. court	None at time of survey	Utilize case managers	Case Managers	Contact person at MCO with DCS contact & monthly report	None at time of survey
MCO/BHO designated contact person	No	MCO has designated person but BHO does not.	Meet quarterly	No	BHO will not return calls	Contact Person	Individual assigned	Yes	No	No
Coordinate services with MCO/BHO	No	No	Some	No	No	Yes	Yes	No	No	Some

Communication between the medical and behavioral organizations was described as sporadic, and in some instances appeared non-existent. Two MCOs reported that BHO staff would not return their calls. One MCO reported "one way" communication with the BHO. Denial files reviewed did not include documentation that communication had taken place between the organizations when a service was denied, or when a member was referred to the BHO.

Most MCOs utilized the provider handbook to disseminate information to PCPs regarding accessing behavioral health services. One MCO did not provide any information to PCPs regarding behavioral health service. The UM Director of this organization stated that all PCPs in the network had access to the BHO toll-free number and referrals were made directly from the physician's office.

BHO providers were informed via Premier's Provider Handbook regarding the process and responsibility for reporting and communicating information to the member's PCP.

Exchange of information and coordination of services between MCO/BHO/DCS appeared disorganized. Identification and tracking of special needs children was difficult. While efforts to facilitate coordination and communication were reported, it appeared that few initiatives had been implemented. Organizations had assigned specific staff to address the needs of the under 21 population, but large caseloads, staff vacancies and the inability to access accurate member location impaired the process.

## Consent Decree Paragraph 39 —EPSDT Tracking and Reminders

Each organization was asked to describe and demonstrate systems they had in place or were planning to implement that would allow them to identify by individual member the EPSDT services rendered and the services due or past due by individual member. As reflected in Exhibit 5 on page 15, the organizations reported a number of internal mechanisms for tracking member services for those under 21. In most cases, methods described were sporadic and unreliable. Although many had plans for implementation, actual review and further discussion with the organization's staff revealed no age or member specific tracking mechanisms were in place. Organizations could not identify and remind members who had not accessed EPSDT services except as described in the following paragraphs.

**Exhibit 5 Monitoring and Tracking**

Activity	MCOs									BHO
	Omni	John Deere	BC/BS	VCC	AMP	PHP	TLC	Prudential	Xantus	Premier
Monitoring to record EPSDT services <u>other than immunizations</u> .*	Dental referrals	No	Lead Screen & Well Child visits	No	No	No	Preventive Services	No	Dental Visits	No
What source do you use for collecting monitoring data?	Claims	MRR	Claims & MRR	Claims	Claims	Claims	Claims	MRR	Claims	Claims
EPSDT STUDIES (other than immunizations).*	Dental	No	Dental	Pediatric Asthma	No	No	Pregnancy & Prenatal	Well Child	Dental	Alcohol/ Drugs

\*All MCOs monitor immunizations

Two organizations initiated programs in mid 1998 to monitor EPSDT services. One organization designed a Birthday Card Program in which cards were mailed to members age 1-6yr including a certificate for a toy. When the member received EPSDT services and returned the card signed by the physician, a toy was mailed to the child. The organization tracked the number of cards returned each month by members who received EPSDT services and the number of toys mailed to members. The Birthday Card Program mailed a total of 32,094 cards to members (1-6yr) in 1998. The return rate for the Birthday Card Program in 1998 was slightly over 2%, or 721 returned cards resulting in gifts sent. The organization did not track the number of cards returned as being undeliverable. Organizational staff expressed plans to expand the program to all children. No consideration was given to either the low response rate or the issue of the large numbers of undeliverables.

Another organization initiated efforts to develop a call list that identified members who had not received EPSDT services in the past year. The call list, generated by the organization's MIS department, listed members under the age of 21, who had birthdays during the current month. Members on the list were contacted via the telephone and encouraged to schedule appointments. This program was recently implemented and data were not available to evaluate its success.

Both organizations voiced concern regarding the accuracy of available address and telephone number information. As a result of inaccurate information, both organizations had experienced difficulty implementing their programs. The Call List program's implementation was complicated not only by inaccurate information, but also with their inability to access telephone numbers for children in state custody due to confidentiality issues.

Most organizations had MIS capability to track EPSDT encounters. However, effective systems for matching this information with due or past due services and accessing current, accurate information for notifying these members and families was not available.

## Consent Decree paragraphs 39, 40, 53-59, 74-76, 77— Service Vendors

Subcontractor representation during the review was minimal; therefore, the assessment of most organizations/subcontractors relationships was limited. The exception was in the area of transportation. Transportation vendor representatives were present at most of the organizations and described service management processes consistent with EPSDT requirements. Although most organizations delegated at least some aspect of complaint management to transportation vendors, only one organization currently received routine complaint reports. Three organizations that subcontracted dental services did not receive vendor reports of service denials or member complaints.

Organization/vendor contracts were generally not available for review. Of contracts which were reviewed, only those revised since June 1998 contained EPSDT information. However, staff at the majority of organizations described plans to incorporate EPSDT elements and the contractual definition of medical necessity.

### Exhibit 6 Services Subcontracted by MCO/BHOs

SUBCONTRACTED SERVICE	MCOs									BHO
	Omni	John Deere	BC/BS	VCC	AMP	PHP	TLC	Prudential	Xantus	Premier
Pharmacy	X		X	X	X		X		X	
Vision	X	X	X	X	X	X	X	X	X	
Transportation	X	X	X	X	X	X	X	X	X	X
Dental	X	X	X	X		X				
Home Health	X	X		X				X		
Durable Medical Equipment	X	X		X				X		
Hospice	X									

## Exhibit 7 Subcontractor routinely reporting to the MCO or BHO

SUBCONTRACTED SERVICE	MCOs									BHO
	Omni	John Deere	BC/BS	VCC	AMP	PHP	TLC	Prudential	Xantus	Premier
Pharmacy	No*		Yes	No	Yes		Yes		No	
Vision	Yes	Yes	Yes	No	Yes	No	Yes	No	No	
Transportation	No	Yes	Yes	No	Yes	No	No	Yes	No	Yes
Dental	No	Yes	Yes	No		No				
Home Health	No	No		No				No		
Durable Medical Equipment	No	No		No				No		
Hospice	No									

\*Omni was in transitional status in regard to pharmacy vendors.

One vision contract placed an annual limit of only one eye exam. The contract further stated the vendor would comply with all federal and state mandates; however, this specific exception or any other EPSDT information was not included in the contract.

Due to the lack of age specific reporting from service vendors to the organizations, the EQRO was unable to identify trends in service denials and member complaints. However, a denial log for January 1998-August 1998, supplied by the East Tennessee Community Services Agency, listed reasons for denial as "automobile" and "state custody." One complaint noted on a non-age specific log was from a mother who reported being denied transportation for her child when another minor child needed to accompany her.

There appeared to be confusion relating to parental accompaniment of minors. Transportation representatives/staff verbalized awareness of the contractual requirement to transport a minor with an escort. Questions concerning parental accompaniment evoked varied responses. Transportation representatives were asked, "What occurs if, upon arrival for scheduled transport a parent refuses to accompany their child?" Responses included, "would contact the MCO/BHO for direction for an unaccompanied minor prior to transport;" "some vendors will transport unaccompanied age 6 and up with driver accompanying child to office;" "would address on case by case basis, if parent not available would not transport;" and "arrangements would be made, the child would receive service".

Although most organizations were attempting to initiate implementation of EPSDT requirements into subcontracted services, without participation of subcontractor representatives it was impossible to generally assess the level of compliance.

## Conclusion

Although all organizations appeared to have an understanding of EPSDT, processes to fully address the management and delivery of services in accordance with requirements of the Consent Decree were not always adequate.

A large amount of member information was distributed through mailings, but there were no effective mechanisms for assuring the entire eligible population was aware of the full scope of EPSDT services. Conclusions concerning appropriateness of denied services and subcontractor compliance were not possible to formulate due to lack of available information. Tracking of EPSDT encounters occurred; however, effective mechanisms to improve member utilization were not fully developed and implemented.

Coordination of care for members under 21 remained a major concern. MCOs had no definite process designed to promote communication with the BHO and reported calls were not returned by the BHO. Neither the MCOs nor the BHO seemed to consider coordination a priority. Coordination of the care of children in state custody was also often absent (see exhibit 4), somewhat due to the lack of accurate and timely identification of these children. When a coverage issue arose in regard to the responsible state entity, such as the school system, it appeared that no one was serving as a facilitator to assist in getting the child the needed services.

Plans for further implementation of processes to meet requirements were described by the organizations' staff. While initiation of these new/revised processes will bring the organizations closer to compliance, there are opportunities for improvement in several areas.

## Appendix A

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## EQRO EPSDT Review

Outreach efforts: Any information related to activities, programs, mailings, or special events that have been implemented or are being planned related to informing members and practitioners of EPSDT benefits and encouraging members to obtain EPSDT services.

EPSDT Policies and Procedures: Any policies or procedures that relate to the provision of EPSDT services, to referrals, or to authorization of EPSDT services that have been developed or modified since our annual survey. Include the policy and procedure for determination and notification of determination of a non-covered service.

Referrals to Medical Director or other Physician Reviewer: Logs of all referrals to physician reviewers, non-authorizations/denials, appeals, and supporting documentation, involving members under 21 during the 1998 calendar year. (Must identify members under age 21). Non-authorization/denial and appeal statistics maintained by the MCO.

Services requiring/not requiring authorization: Lists or other documents that describe which services do and/or do not require pre-authorization.

Tracking and Monitoring: Description of any mechanisms in place to track and monitor PCP referrals to specialists or a higher level of care as related to EPSDT services. Any logs or reports related to this activity. Documentation of other internal monitoring of EPSDT services, including access and availability, provision, or effectiveness.

Transportation Services: Any MCO internal policies, procedures, reports, contracts, complaints/grievance/appeal issues that relate to transportation services. Information including policies, procedures, reports, dispatch logs, and complaint records that the transportation provider utilizes. Any records maintained of transports not authorized. (Please request this information from the transportation provider in sufficient time to have available at the time of the survey. If you desire, a representative from the transportation vendor may participate in this portion of the review.)

Other Service Vendors: Information including policies, procedures, reports, and complaint records that the service vendor utilizes. Any information the vendor may send to their contracted practitioners regarding EPSDT services, any complaint records, and any authorization procedures they utilize including any records they maintain of services not authorized, determined not medically necessary, or to be non-covered. (Please request this information from other service vendors in sufficient time to have available at the time of the survey. If you desire, a representative from the vendor may participate in this portion of the review.)

Qualifications of UM Staff: Policy, job descriptions, procedures for verification. Evidence of procedure adherence for all UM review staff.

Coordination: MCO/BHO agreement describing coordination between the organizations.

Complaints: Complaint logs. (Must identify members under age 21).

Please feel free to share any other processes or documents that you utilize to assure members are informed of EPSDT benefits and receive timely EPSDT services.

MCO \_\_\_\_\_ Date \_\_\_\_\_ Surveyor \_\_\_\_\_

**Outreach and Informing** [reference: EPSDT Consent Decree, paragraph 39-40]

*Purpose of review: to gather information concerning the MCOs' efforts to inform members, providers, and staff about EPSDT.*

*Review period: January 1, 1998 to present*

**Procedure:**

- Review all documents, films, or other information distributed to members, providers, and staff addressing EPSDT. (Examples: policies, procedures, newsletter, letters, brochures, manuals, audio tapes) Complete table below.

	List the type document or other method of communicating(brochure, newsletter program, film, healthfair etc.)	Date printed/developed or date distributed/ presented	Targeted audience P=practitioners PV=providers M=members S=MCO staff	Approved by TennCare (ask if they have letter of approval.) [member only]	Content appropriate for audience(clear and non-technical terms) Details how often service should occur	Follow-up and evaluation of method. Was it successful in reaching target audience?
1.						
2.						
3.						
4.						
5.						
6.						
7.						

	List the type document or other method of communicating(brochure, newsletter program, flm, healthfair etc.)	Date printed/developed or date distributed/ presented	Targeted audience P=practitioners PV=providers M=members S=MCO staff	Approved by TennCare (ask if they have letter of approval) [member only]	Content appropriate for audience(clear terms) Details how often service should occur	Follow-up and evaluation of method. Was it successful in reaching members?
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.						
16.						
17.						
18.						
19.						
20.						

- For each document listed above enter the document number in the table below for each topic covered. (Example if document "1." above talked about dental care, place a "1" in the "dental check" box below.)

EPSTD services (screening)	declining EPSTD services
head to toe physical exam	appointment scheduling and transportation assistance
eye exam	related transportation services, which include meals and lodging, and the cost of an attendant
hearing exam	accessing services
nutrition check	prenatal care for pregnant adolescent (including request of EPSTD services for child at birth)
growth and development check	preventive services
blood and urine test	dental check
immunizations, if needed	referral for treatment as the result of screening
informing families of the costs, if any	limits on services

- Interview responsible staff. (Include name and title of individual answering questions.)

Who is your contact person in MIS?

Name: \_\_\_\_\_ Title: \_\_\_\_\_ Department: \_\_\_\_\_

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What agencies do you work with to assist you in informing individuals who are illiterate, blind, deaf, or cannot understand English?

Name: \_\_\_\_\_ Title: \_\_\_\_\_ Department: \_\_\_\_\_

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Do you have a reminder system? If so, is it event specific or member specific?

Name: \_\_\_\_\_ Title: \_\_\_\_\_ Department: \_\_\_\_\_

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- Interview continued:

Do you routinely get the names of members under 21?

Name: \_\_\_\_\_ Title: \_\_\_\_\_ Department: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

When do new members receive information about EPSDT?

Name: \_\_\_\_\_ Title: \_\_\_\_\_ Department: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How do you coordinate services with the BHO? Do you have a designated contact person at the BHO?

Name: \_\_\_\_\_ Title: \_\_\_\_\_ Department: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

- Interview continued:

How do you coordinate services with other community resources?

Name: \_\_\_\_\_ Title: \_\_\_\_\_ Department: \_\_\_\_\_

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Does each member and provider receive information, in writing and/or verbally about EPSDT?

Name: \_\_\_\_\_ Title: \_\_\_\_\_ Department: \_\_\_\_\_

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Do high risk enrollees receive targeted information regarding EPSDT (families of children with developmental disabilities, children in state custody, pregnant adolescents).

Name: \_\_\_\_\_ Title: \_\_\_\_\_ Department: \_\_\_\_\_

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- Interview continued:

What percent of your membership are hearing impaired? Visually impaired? How do you identify these members?

Name: \_\_\_\_\_ Title: \_\_\_\_\_ Department: \_\_\_\_\_

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What percent of your membership speaks a language other than English? How do you identify these members?

Name: \_\_\_\_\_ Title: \_\_\_\_\_ Department: \_\_\_\_\_

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Is "medical necessity" (as defined by TennCare) distributed in writing to members, providers and service vendors

Name: \_\_\_\_\_ Title: \_\_\_\_\_ Department: \_\_\_\_\_

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- Interview continued:

Additional questions and notes

[illegible]

MCO \_\_\_\_\_ Date \_\_\_\_\_ Surveyor \_\_\_\_\_

### Utilization Management

*Purpose of review: to identify mechanisms the MCO has in place to ensure that services required under EPSDT law are delivered as medically necessary*

#### Preauthorization/UM Referral/Reauthorization/Denial [EPSDT Consent Decree, paragraph 54-59]

*Purpose of review: to identify mechanisms the MCO has in place to ensure utilization controls do not unreasonably delay the initial or continued receipt of services, nor cause recipients to go without medical care*

#### **Procedure:**

- Review policies and procedures. (in context of EPSDT regulations/members under age 21)
- Look for description of services requiring/not requiring authorization.
- Look for requirement for authorization of periodic screens by PCP and interperiodic screens by PCP for suspected problems.

#### *Instructions:*

*There shouldn't be requirement for authorization of screenings by PCP. Authorization can be required for screening by a practitioner other than the PCP; or the MCO can require that the screening be performed by the PCP.*

Look for policies/documents which indicate or stipulate that need for services must be identified by a practitioner whose services were prior authorized or by a participating practitioner.

Look for denial of request due to technicality.

*Instructions:*

*Should not find this requirement for EPSDT services. The MCO can require that the member go back to the PCP or to a network provider for needed service, but cannot ignore the request and cannot deny the request based on those reasons.*

*technicality - such as UR procedure not followed*

Look for documentation regarding "non-covered services."  
Are EPSDT considerations addressed?

*"non-covered" services may require coverage under EPSDT regs*  
*Compare MCO's listed "non-covered" services to the non-covered services listed in the Risk Agreement. Record any that the MCO lists that are not in the RA and request to see letter of approval from TennCare.*

Look for process for concurrent review/reauthorization of ongoing services and services with tentative limits set.

*Any services where tentative limits are imposed should be recorded in the "Limits" section of this tool.*  
*"...utilization controls cannot unreasonably delay ... continued receipt of services, nor ... cause recipients to go without needed care... must be an expeditious*

Who is permitted to submit reauthorization information?  
Is there a toll-free number to access the authorization system?  
Is the phone line staffed during normal business hours?  
Are instructions provided for after hours calls?

*process...to ensure children receive...without interruption....any medically necessary services which exceed tentative limits."*

• Interview UM Manager

Have any changes been made in the denial/appeal processes since the annual EQRO survey was performed?

*Instructions:*  
*Document and verify any changes voiced.*

*Verify answer of no changes.*

Is there a separate process for provider appeals of services requested but not provided different from that for member?

*Document and verify any differences voiced.*  
*Verify answer of same process followed for members and providers*

• Interview UM Review Nurse

Did you receive any instruction or training specific to utilization review and authorization of services for members under 21 years of age? If so, where can I find documentation of the information you received?

*Instructions:*  
i.e. training manual, memo  
Review and document any such  
materials in "Qualifications" section  
of this tool

How are services for members under 21 years of age authorized?

When would you make a referral to a physician reviewer?

When you make a referral to the physician reviewer, how is that done and what information is included?

*Instructions:*

*View referral form or screen. Look for inclusion of member's age or birth date.*

How do you handle a request (for a member under 21) for a service NOT listed by your MCO as a covered service OR listed as a NON-covered service? Is such a request handled differently when made by a member versus a practitioner?

*Such services should have special consideration when requested for a member under age 21.*

Who makes a determination of "non-covered" for a member under 21?

Is such a determination considered a denial?

Is it entered on the denial log? If not, where is the determination recorded?

To whom is a denial notice issued?

*Should be treated as a denial if requested/ordered/prescribed by a practitioner.*

*Both member and provider should be notified.*

How do you handle a request for services by an out-of-network practitioner?

*Instructions:*

*The MCO can require that the member go to the PCP or to a network provider for needed service, but cannot ignore the request and cannot deny the request because it came from an on practitioner.*

*Look for consistency with any policy or procedure noted.*

*Ask to review specific cases to verify answers given.*

*If decision not immediately rendered, is there provision for continuing services while decision is pending?*

*Services continued pending appeal?*

*Per TennCare Appeals Rules & Regs, 10 days notice must be given of denial of continuing service and if appealed within that time, service must then continue till appeal decision rendered.*

*Instructions:*

*Also look for denials when log is*

How do you handle reauthorization of ongoing services (including home health, speech therapy, physical therapy, occupational therapy, etc.)?

Is each request considered a separate service or a continuation of one service?

How often is reauthorization generally required for ongoing services?

If reauthorization isn't requested until the last day of authorized care, what happens?

Do you receive any requests for psychological testing?

How are those handled?

Are they approved?

*reviewed.*

Paul EQRO

- Instructions:*

What do you do when you receive a call and the caller is requesting authorization?

Are there any situations when you would authorize services for members? If so, describe fully.

What would you do if a non-covered service was requested?

*Identify any instances when non-clinical staff are making review determinations and document fully.*

*Identify whether non-clinical staff screen out "non-covered" before referring requests to nurse reviewers.*

*Instructions:*

- Interview Physician Reviewer.

When you receive a referral are you advised of the member's age? \_\_\_\_\_

What kinds of referrals, for members under age 21, do you receive from UR nurses? *ask for examples*

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How do you determine whether a service requested for a member under 21 is covered?

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*"...if required to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services..."*

How do you determine medical necessity of a requested service for a member under 21? *Individual needs of child considered?*

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When do you make referrals to consulting specialists regarding determinations for members under 21?

*Instructions:  
ask for examples*

How are your review determinations recorded?

*Review document or records.*

- Obtain log/supporting documentation of UM referrals to physician reviewer.
- Perform review of log, identifying referrals of requests for services for members under 21. (if age not included in log documentation, determine and implement method to ascertain)

*Utilize "UM Referral Review Worksheet"*

*For possibly unnecessary referral, delay in decision, or other identified concern, review any available supporting documentation and record notes on worksheet.*

Summary of findings:

- Obtain denial/non-authorization log and supporting documentation. If appeal information is not recorded on log, ask for appeal log and cross reference. If MCO has separate appeal processes for practitioners and members, ask for both logs.

*Instructions:*

*If age not included in log documentation, determine and implement method to ascertain.*

- Perform review of log, identifying denials of requests for service for members under 21.

Look for denials made for possibly inappropriate reasons such as:

limit exceeded

“non-covered” ordered/prescribed service

ordered/prescribed by non-participating practitioner

continuing therapy with no progress

Look for questionable denials/non-authorizations that were NOT appealed.

*Can require member to go to network provider.  
Services can be discontinued for lack of progress, but provision for monitoring for resulting deterioration must be made.*

Record member ID and details of denial.

Look for denials of psychological testing.

Summary of findings:

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- Obtain denial/non-authorization statistics for period January 1, 1998 to present. If statistics are not calculated and maintained by the MCO, calculate from provided logs.

*Instructions:*

# denials/non-authorizations for members under 21 \_\_\_\_\_  
# denials/non-authorizations appealed \_\_\_\_\_  
# denials/non-authorizations overturned \_\_\_\_\_  
# denials/non-authorizations upheld \_\_\_\_\_

**Referral to Specialty Care/Practitioner** [reference: EPSDT Consent Decree, paragraph 53]

*Purpose of review: to identify mechanisms the MCO has in place to ensure children can be appropriately referred from one level of screening to another*

**Procedure:**

- Interview UM Manager:

Have any changes been made to referral policies and procedures specific to EPSDT since 6/98?

*If yes, review revised policies and document changes.*

Have any TennCare recommendations specific to your organization been implemented since 7/98?

*Document and verify activities implemented as a result of TennCare recommendations.*

*Instructions:*

How does a PCP get a member to the next level of care? (e.g., dental or vision)  
How is the PCP provided the information about how to get the next level of care?

*If there is a number for the PCP to call, it should connect the PCP directly with someone who can schedule the needed care. There should not be a series of steps to be followed.*

- Review any statistics or reports generated regarding EPSDT referrals.

How have these reports/statistics been utilized?

*Instructions:*

**Limits** [reference: EPSDT Consent Decree, paragraph 57]

*Purpose of review: To identify any absolute limits or monetary caps imposed on EPSDT services by the*

MCO.

**Procedure:**

- Review any policies and procedures/documents containing information about limits.

Look for limits imposed on EPSDT services

Are they tentative or absolute?

*Record findings and compose  
additional questions for staff  
interview.*

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- Interview nurse reviewer:

When you get a request for a service, such as home health, for a disabled or chronically ill child, such as a child with cerebral palsy, how is that handled?

How is that care authorized? How much care can be authorized?

If a specified duration or number of services is authorized, what is the practitioner told about getting additional services?

When authorized care is exhausted, is a request for more services considered as a new service request or continuing service?

*Instructions...*

*Ask to see files of such cases, where tentative limits were set and reauthorization occurred.*

*Record answer.*

*Continuing services should be treated as such and appeal R&R followed: 10 days notice, service continued pending requested appeal.*

Do any services have absolute maximum limits?

**Qualifications** [reference: EPSDT Consent Decree, paragraph 58]

*Instructions:*

*Purpose of review: To identify mechanisms the MCO has in place to ensure authorization decisions are made only by qualified personnel.*

***Procedure:***

- Examine policies and procedures related to review staff qualifications.

Are qualifications addressed for both 1st level reviewers and physician reviewers?  
What are they?

Do case managers authorize services?

Are licensure, education, and experience requirements defined?

If so, are education and experience requirements rigidly adhered to or used as guidelines?

*Briefly list qualifications for each position.*

*If case managers authorize services, verify that qualification are consistent with those stated in UM policy for reviewers.*

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*Instructions:*

How are qualifications validated by the MCO?

For first level reviewers? For physician reviewers?

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- Review job descriptions of UM staff.

*Look for consistency with  
qualification policies and  
procedures?*

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- Review documentation of licensure verification, resumes of review staff, and physician reviewer credentialing files.

*Instructions:  
Confirm qualifications as established  
by MCO.*

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- Review orientation and training materials and documents.

Do they contain information about EPSDT?  
Have all review staff completed the UM orientation process?

*Review documentation to validate.*

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- Review attendance documentation of any EPSDT related inservices provided.

*Instructions:*

Was attendance mandatory or voluntary?

Do attendance records identify position as well as names of attendee?

Determine percentage of staff present at inservices.

Was content of inservices communicated to absentee review staff? By what method?

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MCO \_\_\_\_\_ Date \_\_\_\_\_ Surveyor \_\_\_\_\_

**Service Vendors** [EPSDT Consent Decree, paragraph 39, 40, 53-59, 74-76, 77]

*Purpose of review: To identify and describe how the MCO and its subcontractors make available all services included under EPSDT, inform members and providers of the existence and accessibility of these services, and assess the effectiveness of provision of care and services to members under 21 years of age.*

**Procedure:**

- Identify subcontractors.

*Instructions:*

Have there been any changes in subcontractor status since 6/98?

List names of current subcontractors and service(s) each provides.

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- Review contracts between MCO and subcontractors for relevant EPSDT information.

*Utilize "Contract Review Worksheet"*

Summary of findings:

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- Review subcontractor policies and procedures addressing provision of care and services to members under

*Instructions:*

age 21.

Look for methods to access and obtain care and services.

Look for availability of assistance with scheduling.

Look for authorization requirements.

*Record if these elements are absent or conflict with EPSDT regulations.*

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What information from the above subcontractor policies and procedures is communicated to members/practitioners/providers?

How is the information communicated?

*Ask for evidence.*

*If communicated by MCO, relay to Outreach and Informing surveyor for verification.*

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How has the subcontractor's staff been educated to the above policies, procedures, and processes?

*Ask for evidence.*

- Review subcontractor referral processes.

What action would a subcontractor's practitioner take if an MCO member under 21 presented with a condition/symptom requiring evaluation outside that practitioner's usual scope of practice?

*Instructions:  
Interview subcontractor representative.*

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How are practitioners educated to this process?

*Ask for documentation of any processes described.*

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- Review subcontractor authorization processes.

Do any care/services provided by subcontractors require authorization?

If so, who has authority and responsibility?

*If only require notification to obtain billing identification number, does not apply.*

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*If authorization is not delegated to the subcontractor, process will be reviewed by UM surveyor.*

How are services for members under age 21 authorized by the subcontractor?

What are the timeframes imposed?

What happens if a request is received outside the timeframe?

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How are requests for "non-covered" services handled?

*Instructions:*

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*Ask for supporting documents.*

*If decision not immediately rendered,  
is there provision for continuing  
services while decision is pending?*

What is the process for concurrent review/reauthorization of ongoing services and services with tentative limits set? (e.g. hospitalization, home health, speech therapy)  
How often is reauthorization generally required for ongoing services?  
What happens if reauthorization is not requested until the last day of authorized care/service?

- Review subcontractor's log of requests for services.

Summary of findings:

*Utilize "Subcontractor's Service  
Request Review Worksheet"  
Look for age, timeliness of decision,  
appropriateness of non-authorization  
/denial.*

- Review subcontractor's complaint procedure.

What happens when the subcontractor receives a complaint?  
Is a log maintained?

*Instructions:*

*Ask to review log.  
Utilize "Complaint Review  
Worksheet"*

*Identify complaints lodged by/for members under age 21.*

*Look for EPSDT related issues and record.*

Is any aspect of complaint management delegated to the subcontractor?

If so, what is the subcontractor's process for complaint management?

What mechanism is in place to report complaint information to the MCO?

*Ask for supporting documentation.*

If the MCO receives a complaint about the subcontractor, how is this information reported to the subcontractor?

- Review education procedures regarding complaints:

How does the MCO educate subcontractors regarding management of complaints?

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How do subcontractors educate their providers/practitioners regarding complaint reporting?

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- Review information related to transportation services.

How does the subcontractor handle "no shows" and delays?

What is the process for a member to voice a complaint?

Who does the member contact?

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*Instructions:*

*Ask for supporting documentation.*

*Ask for supporting documentation.*

*Instructions:*

What happens if a member declines a scheduled service?

How are members educated regarding their responsibilities when accessing transportation service?

Look for a policy addressing accompaniment.

Does documentation indicate that the MCO or transportation subcontractor requires parental accompaniment of children or imposes any other restrictions on transport of members under age 21?

*Blanket restrictions should not be imposed.*

*Reasonable requests can be made based on the circumstances (e.g. that an adult with parental consent accompany), but must consider each case individually.*

*Pose "what if" questions.*

What occurs if, upon arrival for scheduled transport, a parent refuses to accompany their child?

How does the MCO assure safety and availability of medical/specially equipped van transport for members under age 21?

*Instructions:*

Does the transportation subcontractor have medical/specially equipped transport vans?

Are policies and procedures in place addressing safety issues related to transport of members under age 21 including, but not limited to:

- availability and utilization of carscans
- required use of seat belts
- provision of access for disabled and special needs members
- availability of a communications system
- emergency protocols

1. III

List all statistical reports available from all subcontractors.

*Instructions:*

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MCO \_\_\_\_\_ Date \_\_\_\_\_ Surveyor \_\_\_\_\_

### Complaints

*Purpose of review: to identify EPSDT related concerns or areas for further review*

#### **Procedure:**

- Obtain complaint reports and evidence of CRAF (for period January 1, 1998 to present) from Customer Service manager.

*Instructions:*

Look for EPSDT related issues identified through trending of complaints.

Look for evidence of analysis and CRAF.

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- Obtain complaint log.

Determine from Customer Services how a complaint filed by an adult regarding service for a child is documented.

*If age not included in log documentation, determine and implement method to ascertain*

Is it entered in the log under the adult ID or the child ID?

Look for inclusion of member age or birthdate.

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- ### Summary of findings:

*Identify complaints lodged by/for members under age 21.*

*Look for EPSDT related issues, such as:*

- *problem accessing needed level of care*
- *transportation issues*
- *preventive services/immunizations*
- *delays in receiving services*
- *inadequate or unclear information about benefits/services*
- *coordination of services*
- *limits on services*
- *interruption/discontinuation of services*

MCO Date Surveyor

MCO/BHO/DCS Coordination [reference: EPSDT Consent Decree, paragraph 31-32, 78-80]

*Purpose of review: to identify mechanisms the MCO has in place to assure that member care is coordinated with the BHO and that the division of operations between the organizations does not cause members to go without needed care.*

Procedure:

Instructions:

- Review MCO/BHO agreement, joint care protocol, or other mutually agreed upon document which describes each organization's responsibilities in coordinating care of members.

Look for description of mechanism for communication of referral and treatment information including positions responsible for this coordination.

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- Review procedures or interview staff to determine mechanisms in place to coordinate with DCS to provide continuity of services and care for children in state custody or at risk for entering state custody.

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- Review information given to PCPs in regard to accessing behavioral health services.

What is the procedure?

Within what timeframes can behavioral health services be arranged?

*Instructions:*

*If there is a number to be called, the PCP should directly reach a party who can schedule needed service*

*If the services are not available within specified timeframes, is considered a denial.*

*Copy whatever the MCO has in writing regarding access of behavioral health care.*

MCO \_\_\_\_\_ Date \_\_\_\_\_ Surveyor \_\_\_\_\_

### EPSDT Monitoring Activities

*Purpose of review: to identify and describe MCO's internal mechanisms for monitoring and evaluating access and availability, provision, and effectiveness of EPSDT services*

#### Procedure:

- Interview QI manager.

*Instructions:  
Ask for documentation.*

What monitoring activities are in place that relate to EPSDT?

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How is the information collected, documented, analyzed, and reported?

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How is the information utilized?

*Instructions:*

*What is done with the information  
beyond reporting?  
What actions were taken because of  
the analyzed findings?*

- Review documentation of EPSDT related monitoring and evaluation activities.

Determine whether service rate monitoring is performed, frequency/time period, and whether displayed/evaluated for changes over time.

Record areas monitored and rates reported for current year to date.

Determine whether EPSDT studies are performed.

*Instructions:*

Record study topics related to EPSDT completed or in progress for current year to date.

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Record notes regarding any other EPSDT monitoring activities reported/documented.

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Look for evidence of CRAF related to monitoring and evaluation activities.

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Determine whether feedback from these activities is provided to practitioners and mechanism for doing so.

*Instructions:*

Can improvements be validated?

*Document evidence of improvements  
resulting from monitoring.*

UM Referral Review Worksheet (Purpose: to identify delays in provision of services to members under 21)

	Member ID	Age	Service Requested	Date of Referral	Reason for Referral			Decision		Date of Decision	Concern
					Coverage	Medical Necessity	Technical	+	-		
1.											
2.											
3.											
4.											
5.											
6.											
7.											
8.											

Notes:

1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

**Subcontractor's Service Request Review Worksheet** (Purpose: to identify delays or failures in provision of services to members under 21)

	Member ID	Age	Service Requested	Date of Request	Date Service Authorized	Timely Decision? (Y or N)	Service NOT Authorized Reason	Denial Notice Appropriate	Concern
1.									
2.									
3.									
4.									
5.									
6.									
7.									
8.									

Notes:

1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

# Complaint Review Worksheet *(Purpose: to identify EPSDT related concerns or areas for further review)*

	Age	Date of Complaint	Nature of Complaint/Notes	Category*	Date Resolved
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

\* Categories: I - information      D - denial, delay, reduction  
A - access                              T - transportation

**Denial, Non-authorization Review Worksheet** (Purpose: to identify question, the denials of service for members under 21)

	Member ID	Age	Service Requested	I	O	Date of Request	Denial Reason/Rationale*	Date of Denial	Inappropriate Denial Possible	Appeal	Service Continued Pending	Appeal Outcome
1.							CVG MN TK					
2.							CVG MN TK					
3.							CVG MN TK					
4.							CVG MN TK					
5.							CVG MN TK					
6.							CVG MN TK					

Notes:

1.	
2.	
3.	
4.	
5.	
6.	

I=initial request O=ongoing service

\* CVG - coverage MN - medical necessity TK - technical

# Utilization Management Statistics

MCO \_\_\_\_\_

Period covered Jan. 1, 1998 through \_\_\_\_/\_\_\_\_/\_\_\_\_

Total # members under age 21	as of ____/____/____
Total # authorization requests for members under age 21	
Total # pended to physician reviewer (for members under age 21)	
Total # denials (for members under age 21)	
Total # appeals for members under age 21 (not claims appeals) provider: _____ member: _____	
Total # rejected requests for "non-covered" services for members under age 21 (if maintained separate from denials)	
Total # of appeal's upheld by TennCare.	
Total # of appeals's overturned.	

Name of  
MCO: \_\_\_\_\_

**Name of Subcontractor Contracted:**

Effective Date of Contract \_\_\_\_\_

Elements	present	absent	Comments
1. Does the contract clearly delineate whether the MCO or the subcontractor is responsible for EPSDT outreach and informing?			
2. Does the contract describe the subcontractor's responsibility for education and outreach?			
3. Is the subcontractor required to provide members with information describing available providers?			
4. Is the MCO required to pre-approve written materials and to monitor educational activities undertaken by the subcontractor?			
5. Is the subcontractor required to provide member material in writing that is readable and easily understood; available, as needed, in the languages of the major population group served?			
6. Does the contract incorporate Part 5 of the HCFA State Medicaid Manual ( which delineates requirements for screens, e.g. lead testing, health education, and age- appropriate laboratory tests)?			
7. Does the contract recognize and incorporate TennCare definition of medical necessity?			
8. Is the MCO required to make special accommodation for children in state custody or who are at risk of entering state custody?			
9. Is the subcontractor prohibited from placing limits on EPSDT services?			
Additional comments:			

Additional comments:

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## Appendix B

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## Definitions

DME	Durable Medical Equipment
OT	Occupational Therapy
PT	Physical Therapy
Service Vendor/Subcontractor	Any organization contracting with the BHO/MCO to provide covered services to members
ST	Speech therapy